SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

CENTER FOR MENTAL HEALTH SERVICES

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT APPLICATION

2007

CALIFORNIA DEPARTMENT OF
Mental Health

SEPTEMBER 1, 2006

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

FY 2007 ☒ **FY 2007-08** ☐

STATE NAME: CALIFORNIA
DUNS #: 80-888-6063

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Mental Health
ORGANIZATIONAL UNIT: Office of the Director
STREET ADDRESS: 1600 9th Street, Room 151
CITY: Sacramento ZIP CODE: 95814
TELEPHONE: (916) 654-2309 FAX: (916) 654-3198

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME & TITLE: Stephen W. Mayberg, Ph.D., Director
AGENCY: Department of Mental Health
ORGANIZATIONAL UNIT: Office of the Director
STREET ADDRESS: 1600 9th Street, Room 150
CITY: Sacramento ZIP CODE: 95814
TELEPHONE: (916) 654-2309 FAX: (916) 654-3198

III. STATE FISCAL YEAR

FROM: July 1, 2007 TO: June 30, 2008

IV. PERSON TO CONTACT WITH ANY QUESTIONS REGARDING THE APPLICATION

NAME & TITLE: Dee Lemonds, Section Chief
AGENCY: Department of Mental Health
ORGANIZATIONAL UNIT: Systems of Care Division
STREET ADDRESS: 1600 9th Street, Room 100
CITY: Sacramento ZIP CODE: 95814
TELEPHONE: (916) 654-3001 FAX: (916) 653-6486
EMAIL: dee.lemonds@dmh.ca.gov

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To be submitted December 1, 2006

PART A: OVERVIEW OF APPLICATION

Introduction

The California Department of Mental Health (DMH) anticipates receiving $54,700,302 in federal block grant monies for Fiscal Year (FY) 2007 (State Fiscal Year 2007-08). This FY 2007 application contains California's response to the requirements of the Public Health Service Act, including the necessary assurance forms and fiscal information demonstrating Maintenance of Effort and Children's Set-Aside (Part B).

State Plan for FY 2006

Part C of the application begins with a general overview of California's public mental health system (Section I), with a special focus on the identification and analysis of the State's service system strengths, needs and priorities (Section II). Part C also contains a brief description of California's managed mental health care program (Medi-Cal).

In its State Plan for FY 2007 (Section III), the DMH will continue efforts to promote the Systems of Care philosophy for adults and older adults with serious mental illness (SMI), and children and youth with serious emotional disturbance (SED), as discussed in this application.

As in last year's application, the DMH has identified at least one goal and one objective for Criteria 1, 2, 4 and 5 for adults and older adults with SMI, and Criteria 1, 2, 3, 4 and 5 for children and youth with SED. The particular objectives were chosen in order to highlight the progress California is making in such areas as the promotion of wellness and recovery of adults and older adults, and resiliency for children and their families; the expansion of services for transitional-age youth; and human resource development in the mental health field.

The DMH will also report data on the Center for Mental Health Services' five National Outcome Measures.

State Plan Implementation Report for FY 2006

As required, Part D (State Plan Implementation Report) of this application will be submitted by December 1, 2006. Part D will contain a report on the purposes for which the Community Mental Health Services Block Grant funds for the prior fiscal year were expended, the recipients of funds provided under the grant, and a description of funded activities. The report will also focus on the extent to which California has implemented its plan for the prior fiscal year, with particular attention given to goals, objectives and performance indicators.

Uniform Data Tables

Continuing this year, the DMH will report uniform data (Part E) on the public mental health system in California. Data that cannot be presented in the tables will be indicated in the State Level Data Reporting Capacity Checklist. This data will be included with the FY 2006 State Plan Implementation Report due December 1, 2006.

The California Mental Health Planning Council

The California Mental Health Planning Council is an active participant in the planning and review process. The Planning Council's comments on the application, as well as the DMH's response to those comments, are included.

PART B: APPLICATION INFORMATION

Attachment A
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2007

I hereby certify that _____CALIFORNIA_____ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2002, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psycho social rehabilitation programs, mental health peer-support

[1] The term State shall hereafter be understood to include Territories.

programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")

(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.

(C) 24-hour-a-day emergency care services.

(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner, which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are–

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of–

(A) the principle State agencies with respect to–

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding,

and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that–

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912 (a) with respect to the grant and the report of the State under section 1942 (a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912 (a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942 (a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant–

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit public entity.
(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public

within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of--

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will–

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will–

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor (or Designee) Date

OMB Approval No. 0920-0428

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
  (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

PUBLIC COMMENTS ON THE 2007 STATE PLAN

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide the opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner as to facilitate comment from any person (including federal or other public agency) during the development of the plan (including any revisions) and after submission of the plan to the Secretary.

To accomplish this goal, California will post the State Plan on its main web-site at www.dmh.ca.gov for public review and comments.

The public may either download the State Plan or view it on-line, and then offer comments via e-mail to an identified contact person from DMH. Agencies that do not have access to a computer or the Internet will be able to request (via First Class mail) one hard-copy of the 2006 State Plan and forward any comments in writing to the Department.

August 10, 2004

Ms. LouEllen M. Rice
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
Parklawn, Room 13-103
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Rice,

This letter is to inform you that I designate S. Kimberly Belshé, Secretary, Health and Human Services Agency, to sign on my behalf the set of agreements that certify our State's compliance with requirements for receiving funds under the Substance Abuse and Mental Health Service Administration, Center for Mental Health Services Block Grant program.

Sincerely,

Arnold Schwarzenegger

MAINTENANCE OF EFFORT (MOE)

In this subsection, California has provided information that is sufficient to enable the Secretary to make a determination of compliance with the statutory MOE requirements. Specifically, the information provided below documents that California has maintained expenditure for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the two-year period preceding the fiscal year for which this grant application is being made. We have excluded from aggregate State expenditures funds appropriated to the Department of Mental Health for authorized activities that are of a non-recurring nature and for a specific purpose.

State Expenditures for Mental Health Services

Actual SFY 2002-03	Actual SFY 2003-04	Actual SFY 2004-05	Estimated Expenditures SFY 2005-06	Estimated [1/] Expenditures SFY 2006-07
$ 1,442,959,000	$ 1,454,562,000	$ 1,449,169,000	$ 1,506,655,000	$ 1,942,105,000

[1/] Of the amount shown here a total of $346,428,000 was previously shown in the Department of Health Services Budget and $52,000,000 is attributed to a new categorical program now included in the Department of Mental Health's budget.

SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES

In this subsection, California has provided information on expenditures for systems of integrated services for children with Serious Emotional Disturbance. This information shows that the State has not expended less than the calculated amount for State Fiscal Year 1994-95.

DATA REPORTED BY:

State FY 2007-08 Federal FY 2007

State Expenditures for Mental Health Services

Calculated SFY 1994-95	Actual SFY 2005-06	Estimated SFY 2006-07	Estimated SFY 2007-08
$ 160,683,000	$ 275,986,000	$ 280,011,000	$ 286,029,000

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL CHARGE

5771. (a) Pursuant to Public Law 102-321, there is the California Mental Health Planning Council. The purpose of the planning council shall be to fulfill those mental health planning requirements mandated by federal law.
(b) (1) The planning council shall have 40 members, to be comprised of members appointed from both the local and state levels in order to ensure a balance of state and local concerns relative to planning.
(2) As required by federal law, eight members of the planning council shall represent various state departments.
(3) Members of the planning council shall be appointed in such a manner as to ensure that at least one-half are persons with mental disabilities, family members of persons with mental disabilities, and representatives of organizations advocating on behalf of persons with mental disabilities. Persons with mental disabilities and family members shall be represented in equal numbers.
(4) The Director of Mental Health shall make appointments from nominees from mental health constituency organizations, which shall include representatives of consumer-related advocacy organizations, representatives of mental health professional and provider organizations, and one representative of the California Coalition on Mental Health.
(c) Members should be balanced according to demography, geography, gender, and ethnicity. Members should include representatives with interest in all target populations, including, but not limited to, children and youth, adults, and older adults.
(d) The planning council shall annually elect a chairperson and a vice chairperson.
(e) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

5771.3. (a) The California Mental Health Planning Council may utilize staff of the State Department of Mental Health, to the extent they are available, and the staff of any other public or private agencies that have an interest in the mental health of the public and that are able and willing to provide those services.

5771.5. (a) (1) The chairperson of the California Mental Health Planning Council, with the concurrence of a majority of the members of the California Mental Health Planning Council, shall appoint an executive officer who shall have powers delegated to him or her by the council in accordance with this chapter.
(2) The executive officer shall be exempt from civil service.
(b) Within the limit of funds allotted for these purposes, the California Mental Health Planning Council may appoint other staff it may require according to the rules and procedures of the civil service system.

5772. The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:
(a) To advocate for effective, quality mental health programs.

(b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Mental Health, local boards, and local programs.
(c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:.
(1) To review and approve the performance outcome measures.
(2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Mental Health and other sources.
(3) To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Mental Health, and the local boards.
(4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.
(d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Mental Health shall investigate and review the finding, and report the action taken to the Legislature.
(e) To advise the Legislature, the State Department of Mental Health, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
(f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.
(g) To make recommendations to the State Department of Mental Health on the award of grants to county programs to reward and stimulate innovation in providing mental health services.
(h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.
(i) To participate in the recruitment of candidates for the position of Director of Mental Health, and provide advice on the final selection.
(j) In conjunction with other statewide and local mental health organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.
(k) To advise the Director of Mental Health on the development of the state mental health plan and the system of priorities contained in that plan.
(l) To assess the effect of realignment of mental health services from the state to the counties on the delivery of those services, and report its findings to the Legislature, the State Department of Mental Health, local programs, and local boards no later than January 1, 1995
(m) To suggest rules, regulations, and standards for the administration of this division.
(n) When requested, to mediate disputes between counties and the state arising under this part.
(o) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.
(p) To accept any federal fund granted, by act of Congress or by executive order, for purpose within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.
(q) To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purpose within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL ROLES AND ACTIVITIES

The California Mental Health Planning Council (CMHPC) has been an invaluable instrument for public involvement in mental health planning. It has been particularly effective as a vehicle for the involvement of clients and families. In addition to the federal planning duties, state law includes additional responsibilities and duties that are critically important to the provision of public input, such as system accountability and oversight.

The duties of the CMHPC include:

- Advocating for effective, quality mental health programs;
- Reviewing, assessing, and making recommendations regarding all components of the mental health system, and reporting, as necessary, to the Legislature, the DMH, local boards, and local mental health programs;
- Reviewing program performance in the delivery of mental health services by annually reviewing performance outcome data and reporting findings and recommendations to the DMH, the Legislature, and local mental health programs;
- Advising the Legislature, the DMH, and county boards on mental health issues, policies, and priorities that the State should be pursuing;
- Reviewing the State's data systems and paperwork requirements to ensure they are reasonable;
- Participating in the recruitment of candidates for Director of Mental Health;
- Making recommendations to the DMH on the awarding of grants to county programs to reward and stimulate innovation;
- Conducting public hearings on the State mental health plan, the Mental Health Block Grant, and other topics as needed;
- Assisting in the coordination of training and information dissemination to local mental health boards;
- Advising the Director on the development of the State mental health plan and its priorities;
- Suggesting rules, regulations, and standards for the administration of mental health programs;
- Mediating disputes between the State and counties when requested; and
- Accepting federal or private grants and donations.

The CMHPC is organized into four standing committees. Three committees focus on policy issues consistent with the priorities agreed on by the membership: the Human Resources Committee, the Quality Improvement Committee, and the Policy and System Development Committee. The fourth

standing committee, the System of Care Committee, addresses system of care and treatment issues for children and youth, adults, and older adults. The CMHPC also will continue to advise the DMH regarding the federal block grant application, including the PL 106-310 State Plan for Comprehensive Community Mental Health Services.

The CMHPC's committees are currently focusing their energy and attention on a number of projects:

- The System of Care Committee's subcommittees each have projects on which they are working:

  - The Children and Youth System of Care Subcommittee has assumed responsibility for the Planning Council's recent mandate, acquired with the passage of Chapter 71, Statutes of 2003 (AB 376, Chu), to review and monitor the implementation of counties' efforts to improve the provision and quality of mental health services to foster children.

  - The Adult system of Care Subcommittee is focusing on oversight of the state hospitals. This project will review the findings of the recent United States Department of Justice audit, pursuant to the Civil Rights Institutionalized Persons Act. The Subcommittee will be working closely with the DMH to ensure that corrective actions are being implemented in the state hospitals.

  - The main priority of the Older Adult System of Care Subcommittee (OASOC) is projects related to advocating for an Older Adult System of Care in every county. The OASOC will examine the availability of data in the Mental Health Services Act (MHSA) Community Services and Supports plans and subsequent monitoring reports to determine the expansion of services for older adults. The subcommittee is studying various data on older adults, including the prevalence of mental illness among older adults as well as older adults' utilization of mental health services in the public mental health system. Fragmentation of local older adult services and statewide planning efforts related to coordination of these services is another issue the subcommittee is exploring.

- The Quality Improvement Committee has several on-going responsibilities that form the foundation of the committee's work: 1) participating in the development of a quality improvement system for the public mental health system, and 2) providing oversight of the DMH and county mental health programs. Developing a quality improvement system relates to a mandate in state law that the DMH develop performance outcome measures to assess whether mental health services improve the quality of clients' lives and are cost effective. The CMHPC has developed an approach to system oversight and accountability and has proposed a comprehensive set of performance indicators that can be found in the *California Mental Health Master Plan: A Vision for California.*[1] The CMHPC also works closely with the DMH's State Quality Improvement Council to devise strategies for quality improvement for the State's mental health system.

  One of the CMHPC's other primary responsibilities is to work with county mental health boards and commissions to help them understand and interpret their data collected on performance indicators at the local level and to provide information that can be used for the CMHPC to

[1] This publication can be accessed at the CMHPC publication website: http://www.dmh.ca.gov/MHPC/reports.asp

develop statewide reports. The committee is developing a workbook that will provide county mental health boards and commissions with a uniform reporting format. This workbook will also provide specific performance indicators on which they can report with sufficient background information to help boards and commissions better understand and interpret the data within their local context.

The Quality Improvement Committee's other current projects consist of monitoring the development of the implementation of the MHSA and providing input to the design of the performance measurement system. The CMHPC is mandated in the Welfare and Institutions Code Section 5772(c)(1) to review and approve performance measures. Consequently, it will have to approve the design of the performance measurement system developed for the MHSA. In addition, the Quality Improvement Committee is monitoring trends in compliance and quality improvement issues in county mental health programs by periodically reviewing the Medi-Cal on-site reviews that the DMH conducts of mental health plans and the external quality reviews conducted by APS, the external quality review organization for California.

- The Policy and System Development Committee is focusing on how the implementation of the MHSA will affect the entire public mental health system and be integrated into the system. The committee has designated representatives who attend and report back on all of the implementation work groups. The committee is facilitating the review of the *California Mental Health Master Plan* to determine how its recommendations will help California in its mental health system transformation.

- The Human Resources Committee is continuing its activities on the Human Resource Project, addressing the critical human resources needs of the mental health system in California. This project is discussed in greater detail under Criterion 5: Management Systems for Adults and Children.

The CMHPC has also established a time limited work group to develop a cultural competence plan.

- The Executive Committee is committed to ensuring cultural competence is embedded into each decision making process affecting the mental health system. The promotion of cultural awareness and the value of diversity will be incorporated into each cultural competence plan. The plan will facilitate the decrease of barriers and inequalities for underserved racial, ethnic and culturally diverse populations that access mental health services. To compliment the effectiveness of the plan, the integration of cross-cutting measures will be applied to include congruent behaviors, attitudes, and policies that enable the system, agencies and mental health professionals to function effectively in cross-cultural institutions and communities.

TABLE 1
CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
MEMBERSHIP LIST

NAME	TYPE OF MEMBERSHIP	AGENCY / ORGANIZATION	ADDRESS, PHONE AND FAX
Celeste Hunter	Family Member - Parent of SED Child		2051 Hawkins Way Spring Valley, CA 91977 (619) 337-1247 Fax: (619) 337-1247
Karen Hart	Family Member - Parent of SED Child		291 San Bernabe Dr. Monterey, CA 93940 (831) 373-3966 Fax: (831) 373-3966
Renee Becker	Family Member – Parent of SED Child		9707 Magnolia Ave. Riverside, CA 92503 (951) 358-6884 Fax: (951) 687-3478
Doreen Cease	Family Member		2717 Mary Street La Crescenta, CA 91214 (818) 957-6921 Fax: (818) 249-2061
Luis Garcia, Ph.D.	Family Member		Pacific Clinics 800 South Santa Anita Avenue Arcadia, CA 91006 (626) 254-5009 Fax: (626) 294-1077
VACANT	Family Member		
Brandon Nunes	Family Member		8916 Lanier Way Sacramento, CA 95826 (916) 362-9407 Fax: (209) 369-3166
Bettye Randle	Family Member		740 Twenty First Street Richmond, CA 94801 (510) 412-0481 Fax: (510) 412-0481
Carmen Lee	Direct Consumer		1572 Winding Way, #A Belmont, CA 94002 (650) 592-2345
George Fry, Jr.	Direct Consumer		P.O. Box 35 Angels Camp, CA 95222 (209) 736-4868 Fax: (209) 736-4868

NAME	TYPE OF MEMBERSHIP	AGENCY/ ORGANIZATION	ADDRESS, PHONE AND FAX
VACANT	Direct Consumer		
Joseph Mortz	Direct Consumer		1010 University Ave., PMB# 390 San Diego, CA 92103 (858) 427-6394
VACANT	Direct Consumer		
Alice Washington	Direct Consumer		2125 19th St. 2nd Fl. Sacramento, CA 95818 (916) 556-3480, ext. 139 Fax: (916) 446-4519
Walter Shwe	Direct Consumer		1915 El Dorado Place Davis, CA 95616 (530) 753-2075 Fax: (530) 753-2076
VACANT	Direct Consumer		
Beverly Abbott	Cons-Rel Advct.		13000 Skyline Blvd. Woodside, CA 94062 (650) 851-8469 Fax: (208) 361-3109
VACANT	Cons-Rel.Advct.		
VACANT	Cons-Rel.Advct.		
Adrienne Cedro Hament	Cons-Rel Advct.		5050 S. Vermont Ave. 6th Fl Los Angeles, CA 90023 (213) 639-6378 Fax: (213) 351-2026
Jonathan Nibbio	Profess/Provider		4251 South Higuera St., Suite 100 San Luis Obispo, CA 93403 (805) 781-3535 Fax: (805) 781-3538
Barbara Mitchell	Profess/Provider		Interim Inc. P.O. Box 3222 Monterey, CA 93942 (831) 649-4522 Fax: (831) 647-9136
VACANT	Profess/Provider		

NAME	TYPE OF MEMBERSHIP	AGENCY / ORGANIZATION	ADDRESS, PHONE AND FAX
Jorin Bukosky	Profess/Provider		623 58th Street Lower Front Flat Oakland, CA 94609 (510) 882-9771 Fax: (415) 776-1018
Susan Mandel, Ph.D.	Profess/Provider		800 South Santa Anita Ave. Arcadia, CA 91006 (626) 254-5000, ext. 5001/5101 Fax: (626) 294-1078/294-1077
Dale Mueller, Ed.D, RN	Profess/Provider		1327 Brookside Ct. Upland, CA 91784 (909) 920-5854 Fax: (909) 920-6046
Diane Koditek	Profess/Provider		P.O. Box 714 Kernville, CA 93238 (661) 868-6608 Fax: (661) 868-6847
Ed Walker	Profess/Provider		50 Van Tassel Court San Anselmo, CA 94960 (415) 453-4586
John Ryan	Profess/Provider		199 N. Morning Glory St. Brea, CA 92821 (714) 528-2498 Fax: (714) 309-2541
VACANT	Profess/Provider		
Stephanie Thal	Profess/Provider		PO Box 2137 Kernville, CA 93238 (760) 376-4448 Fax: (760) 376-6700
Daphne Shaw	Profess/Provider	CA Coal. for MH	P.O. Box 690040 Stockton, CA 95269-0040 (209) 952-2186 Fax: (209) 467-6513
Susan Nisenbaum	State Employee	Department of Social Services	744 P St., Mail Station 11-83 Sacramento, CA 95814 (916) 651-6200 Fax: (916) 651-6239

NAME	TYPE OF MEMBERSHIP	AGENCY / ORGANIZATION	ADDRESS, PHONE AND FAX
VACANT	State Employee	Department of Health Services	
Mike Greenlaw	State Employee	Department of Housing and Community Development	1800 3rd Street, Rm 390-5 Sacramento, CA 95814 (916) 327-3630 Fax: (916) 445-0117
Margaret McAloon, PhD	State Employee	California Department of Corrections	Healthcare Services Division PO Box 942883 Sacramento, CA 94283 (916) 324-6102 Fax: 9916) 322-2838
VACANT	State Employee	Health and Human Services Agency	
Lana Fraser	State Employee	Department of Rehabilitation	2000 Evergreen Street Sacramento, CA 95815 (916) 263-8744 Fax: (916) 263-7495
Michael A. Borunda	State Employee	Department of Mental Health	1600 9th Street, Room 130 Sacramento, CA 95814 (916) 651-9400 Fax: (916) 654-5591
Jim Bellotti	State Employee	State Department of Education	1430 N Street, Suite 2401 Sacramento, CA 95814 (916) 323-6711 Fax: (916) 327-3706

TABLE 2

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

COMPOSITION BY TYPE OF MEMBER

TYPE OF MEMBERSHIP	NUMBER	PERCENTAGE OF TOTAL MEMBERSHIP
TOTAL MEMBERSHIP	**30***	
Consumers/Survivors/Ex-patients (C/S/X)	5	
Family Members of Children with SED	3	
Family Members of Adults with SMI	4	
Vacancies (C/S/X & family members)	6	
Others (not state employees or providers)	2	
Total C/S/X, Family Members & Others	**14**	47%
State Employees	6	
Providers	10	
Vacancies	4	
Total State Employees & Providers	**16**	53%

* Vacancies not included in totals

California Mental Health Planning Council

CHAIRPERSON
Beverly K. Abbott
EXECUTIVE OFFICER
Ann Arneill-Py, PhD

August 4, 2006

Stephen W. Mayberg, PhD, Director
Department of Mental Health
1600 9th Street
Sacramento, CA 95814

Dear Dr. Mayberg:

The California Mental Health Planning Council (CMHPC) is commenting on the Substance Abuse and Mental Health Services Administration (SAMHSA) Community Mental Health Services Block Grant Application for Federal Fiscal Year 2007 to fulfill our federal statutory obligation.

The CMHPC is pleased to have assisted the Department of Mental Health (DMH) in identifying the goals and objectives in the criteria in the application. We believe that this collaboration reinforces our supportive working relationship and produces a Block Grant Application that reflects the shared values of the Administration and the mental health constituency. We have reviewed these objectives, and we concur that they will provide a valid method to determine whether the goals for the criteria have been met.

We have the following specific comments to make on the Block Grant Application:

- **Page 43[1]: Significant Achievements in Areas Needing Attention/New Developments and Issues.** The California Mental Health Disease Management (CalMEND) project should be mentioned as a significant project underway. CalMEND is an important service that will provide access to quality mental health services and includes collaborative efforts between various state departments and counties, consumer and family education, and evidence-based practices such as medication algorithms, peer counseling, and case management.
- **Page 44[1]: Mental Health Services Act (MHSA) of 2006.** We are pleased that the implementation of the MHSA has included an extensive stakeholder process to consider input from all perspectives. The involvement of stakeholders is critical to the success of implementing each component of the MHSA. The vision of the MHSA addresses critical needs and priorities to improve access to effective, comprehensive, and culturally and linguistically competent expanded county mental health services and supports. Stakeholder input provides viable participation to ensure effective outcomes.

[1] There is an error in pagination in the document. These are the first set of pages numbered 43-48 in Section II.

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- **Page 49 Education and Training.** The CMHPC is statutorily mandated in its role to provide oversight to the DMH on policy and development of the five-year plan. Our function is to review and approve the five-year Education and Training Plan.
- **Pages 49-50: Mental Health Services Act (MHSA of 2006).** The CMHPC recommends that the implementation dates and specific amount of funds that will be dispersed by certain dates be deleted in the following subsections due to the fluidity of the planning for the MHSA:

  → Education and Training

  → Prevention and Early Intervention

  → Innovation

- **Pages 68-70: Long Term Care Services/Actions To Improve Program Performance.** The section on Long Term Care Services completely omitted any discussion of the Civil Rights of Institutionalized Persons Act (CRIPA) investigations at the state hospitals and the resulting consent judgment and provisional requirements intended to improve conditions at the state hospitals. This judgment will enhance treatment and patient care while providing patients and staff with a safer environment. Several paragraphs on pages 53-54 describe changes being made to treatment services at the state hospitals consistent with the requirements of the consent judgment, but they are not presented in that context. In addition, we recommend that the Block Grant Application briefly summarize the accountability and monitoring provisions of the consent judgment.
- **Page 86: Eliminating Mental Health Disparities to Racial Ethnic Populations/Cultural Competence.** The CMHPC commends the DMH's efforts to eliminate disparities to racial/ethnic communities in mental health services. The MHSA Community Services and Supports (CSS) three-year program and expenditure plan requirements should facilitate this effort. However, we are concerned that many CSS plans did not adequately embed culturally and linguistically appropriate care into their proposed programs. We would like to see that future department activities increase technical assistance to counties. The California Brief Multicultural Competence Training Program, for example, is a step forward to assessing staff competencies and targeting training.
- **Pages 118 & 194: State Level Refinements of Prevalence Rates and SMI/SED Definitions.** These sections refer to a work group that developed a recommendation on how to collect data on diagnosis and level of functioning in order to refine the definition of SMI/SED. They refer to the work product being completed in mid-2005. In fact, that project was completed, and the results should be incorporated into these analyses and discussions.
- **Pages 190-192: State Plan for Children—Mental Health System Data Epidemiology Criterion.** Instead of explicating the prevalence rates of serious emotional disturbance among children and youth and unmet need in that population, this section is a duplication of the adult and older adult Mental

Health System Data Epidemiology section. We suggest the DMH omit this section and insert data on children and youth.

We hope you have found these comments to be helpful. We value the partnership we have forged with the DMH over the years and look forward to continuing to work together on future Block Grant applications and implementation reports. Please contact Sandra Lyon, the Planning Council's Deputy Executive Officer, at (916) 445-1196 or sandy.lyon@dmh.ca.gov if you have any questions.

Sincerely,

Beverly Abbott
Chairperson

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

August 16, 2006

Beverly Abbott, Chairperson
California Mental Health Planning Council
1600 9th Street
Sacramento, CA 95814

Dear Ms. Abbott:

Thank you for the California Mental Health Planning Council's (CMHPC) letter of August 4, 2006 regarding the Department of Mental Health's (DMH) application for the Center for Mental Health Services Community Mental Health Services Block Grant for Fiscal Year (FY) 2007. The Department has modified the application in response to the specific comments contained in your letter.

The CMHPC assistance, especially in developing the goals and objectives for FY 2007, is very much appreciated.

The following are the DMH responses to the CMHPC's specific comments and recommendations:

- We agree with the CMHPC that the California Mental Health Disease Management (CalMEND) presents a significant effort to improve health outcomes and promotes recovery of clients with serious mental illness. As recommended, we have included a brief description of that program in the application.

- We appreciate the supportive working relationship on implementation of the Mental Health Services Act (MHSA) and want to assure the CMHPC that we will continue to involve stakeholders in the development of each of the components of the MHSA.

- We acknowledge the significant role the CMHPC has in the Education and Training component of the MHSA and have modified the application to reflect this role.

  The Education and Training component of the MHSA specifies that each county mental health program submit to the DMH a needs assessment identifying shortages in each professional and other occupational category and a plan to increase the supply of professional and other staff that county mental health programs anticipate they will require. The CMHPC is required by the MHSA to "advise the State Department of Mental Health on education and training policy development and provide oversight for the department's education and training plan development."

The DMH is also required to identify the total statewide needs for each professional and other occupational category and develop a five-year education and training development plan. The MHSA requires that each five-year plan be "reviewed and approved by the California Mental Health Planning Council."

- We understand and agree with the CMHPC's concerns about using specific implementation dates and funding amounts in the description of the Education and Training, Prevention and Early Intervention and Innovation components of the MHSA. Per your recommendation, we have deleted that specificity from the application.

- As recommended by the CMHPC, the section on Long Term Care Services has been modified to include specific discussion of the United States Department of Justice (USDOJ) investigation pursuant to the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA). That discussion also includes a summary of the accountability and monitoring provisions of the consent judgment.

- The DMH appreciates both your commendation on DMH's effort to eliminate disparities to racial/ethnic communities in mental health services and your concern about cultural and linguistically appropriate care as it is reflected in many of the Community Services and Support (CSS) plans.

  Consistent with the CMHPC's recommendation, the DMH has a number of regional trainings planned on a variety of topics including recovery oriented programs, housing and employment. There are also trainings specific to cultural and linguistically appropriate care that include: Mental Health Interpreter Training; Recovery Oriented/Culturally Competent Service Plan Training; Multicultural Curriculum for Improving Service Delivery and Increasing Cultural Competence; Multicultural Competency Scale Training, etc.

- The CMHPC is correct in pointing out that the workgroup that was utilized to work on refining the definition of SMI/SED has been completed. Per your recommendation, that section, of criterion two, has been modified for both the child and adult section.

  The Data Infrastructure Grant (DIG) utilized a workgroup process to address, among other things, the quality of reporting and the data elements it is using to estimate the SMI/SED client population. The DIG recommendations resulted in changes to the DMH's Client and Service Information (CSI) system, which are being implemented beginning July 2006. The DMH has changed to a DSM IV Text Revision (TR) five axis diagnosis. Since this includes functioning level it is expected that this will give the DMH a more accurate estimate of the number of clients who are SMI/SED.

- Lastly, the CMHPC correctly points out that criterion two or the Mental Health System Data Epidemiology section for the child plan is, in large part, duplicative of the adult

plan. The data in the criterion two sections cover both children and adults and have the same source. As such, the narrative sections are very similar and tend to highlight the same issues. This duplication is consistent with applications approved in past years.

As in past years, I would like to express our ongoing appreciation for the excellent cooperation the CMHPC and its staff have provided in assisting my staff in the completion of this application. We look forward to continuing this positive working relationship as the new fiscal year unfolds.

Sincerely,

STEPHEN W. MAYBERG, Ph.D.
Director

PART C: STATE PLAN

Section I: Description of the State Service System

MISSION STATEMENT

"The California Department of Mental Health (DMH), entrusted with leadership of the California mental health system, ensures through partnerships the availability and accessibility of effective, efficient, culturally competent services. This is accomplished by advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services."

CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

California's public mental health system has evolved over the last four decades. This evolution has changed the role of the State and local governments in providing care. Mental health services have moved from being predominately hospital-based and provided by the State, to community-based and provided through local governments. In recent years, mental health stakeholders recognized that mental health care requires an array of services that have not traditionally been available through a community-based service model. For instance, institutional care provides housing, social activity, transportation assistance, vocational, rehabilitation and physical health care. Community mental health programs historically have provided more limited services.

Multiple State agencies provide health, mental health and related services. The primary agency for ensuring the provision of mental health services is the DMH. It operates State Hospitals, oversees county-based mental health services and provides leadership on issues of policy and practice. The Department of Health Services is California's lead agency for Medi-Cal, which funds the treatment of some clients. The Department of Alcohol and Drug Programs, Department of Housing and Community Development, Department of Rehabilitation and multiple others offer services or coordinate programs available to mental health clients. The primary public providers of mental health services are California's 58 county mental health agencies and two city agencies (Berkeley and Tri-City), the majority run by county governments.

MENTAL HEALTH REALIGNMENT

In 1991, State legislation was enacted that realigned fiscal and administrative responsibility under county authority. This represented a landmark action to restructure government. Realignment provided a more stable funding base for local mental health programs, appropriately shifted program operation and accountability to the local level, and brought about many changes in State administration of mental health services. Realignment also strengthened the cooperative relationships between the State and counties. As a result, the State now has significant responsibilities to maintain system oversight and integrity, and to facilitate and enable the counties to effectively provide needed mental health services.

State Responsibilities

- Provides a dedicated funding source for mental health services with predictable growth, thus enhancing program stability and encouraging program redesign consistent with systems of care research findings;

- Is accountable for performance outcomes; and

- Provides system leadership, administration of federal funds, program oversight and evaluation, and provides specified direct services including State hospitals and services for the forensic population.

County Responsibilities

- Is responsible for program design at the local level, which maximizes participation in decision-making by clients, families and advocates, and encourages diversity and program experimentation;

- Conducts integrated planning of community and long-term care systems at the local level; and

- Determines how county funds will be transferred among sub-accounts for mental health, public health, and social services.

In response to the structural changes brought about by realignment, the DMH now focuses its activities on these primary areas: systems of care, program compliance, and long-term care. State staff interface with counties through provision of technical assistance and consultation to enable systems of care and innovation locally. Considerable effort has been dedicated to restructuring and innovative program design and development at the State Hospital campuses.

In summary, the State is responsible for maintaining system oversight and integrity, in order to assist counties in providing effective, critically needed services. Effective local services and coordination of major system changes and improvements are made possible because of the centralized oversight and facilitation roles played by the State.

DEPARTMENT OF MENTAL HEALTH RESPONSIBILITIES

At the State level, the DMH is responsible for:

- Leadership;

- Administration of federal funds;

- System oversight, evaluation, and monitoring;

- Direct services; and
- Administrative support.

Leadership

The primary role of the DMH is to provide leadership to the mental health system including planning, research, technical assistance, education, quality assurance, and program development of a broad array of initiatives for local services. Leadership activities include, but are not limited to:

- Implementing the State mission and goals for mental health services;
- Advocating for quality mental health services for California's citizens with mental illness;
- Maximizing the ability to utilize creative public and private financing opportunities;
- Providing appropriate planning, research, technical assistance, training, and program development; and
- Encouraging ongoing collaborative efforts between clients, family members, providers and other members of the mental health constituency as well as interagency and cross-jurisdictional collaboration at the State level.

Administration of Federal Funds

- The DMH is also responsible for securing and ensuring the continuation of federal funds. All tasks related to the administration of federal funds, such as utilization review, quality management, and cost reporting and settlement are included in this category. This includes the administration of federal funding for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit; Medi-Cal-funded psychiatric inpatient hospitals; Short Doyle/Medi-Cal (SD/MC); the annual Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant; and the annual Projects for Assistance in Transition from Homelessness (PATH) formula grant.
- The DMH also administers federal funding under the Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program following a Presidential Disaster Declaration and evident need for disaster mental health services that cannot be met through local government or state resources. Over $71 million in Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program funds have been awarded to California since 1989 to alleviate mental health problems caused by the massive devastation of earthquakes, fires, civil unrest, freeze and winter storms.

  The Department also administers a SAMHSA capacity expansion grant to improve the capacity of the DMH and the California Alcohol and Drug Programs Department to respond to all-hazards emergency events.

  The DMH Disaster Assistance Coordinator participates on numerous task force and workgroups oriented toward emergency preparedness, response and recovery for both natural disasters and terrorist events.

System Oversight, Evaluation and Monitoring

The DMH is responsible for overseeing the delivery of public mental health services in California. The following DMH tasks related to oversight of programs or funds are included in this category:

- Research, evaluation and monitoring of performance outcomes; Medicaid compliance; and all elements of the State system of care for adults and older adults with serious mental illness, and children with serious emotional disturbance;

- Negotiation of performance contracts and implementation plans with counties for the administration of local mental health programs;

- Licensing and certification of clinics and facilities;

- Rate-setting;

- Assurance of, and monitoring of, patients' rights;

- Operation of the Ombudsman Office (see next page);

- Dissemination of data; and

- Oversight of the managed mental health care plan.

Direct Services

The DMH provides the following services either directly or through contract:

- Oversight of direct services provided through contracts with public or private entities, or with inter-governmental agreements;

- Direction and monitoring of programs for offenders with mental disabilities conditionally released into the community;

- Administration of programs and activities mandated by the Legislature;

- Operation of the State hospitals for individuals with mental disorders who have been placed either by counties according to the civil commitment statutes, or by courts or prisons in accordance with the Penal Code;
- Operation of the Sexually Violent Predator (SVP) program; and

- Operation of programs in prisons for offenders with mental illness under contract with the California Department of Corrections.

Administrative Support

The DMH also performs the administrative functions necessary to support its operation. These functions generally include:

- Personnel;
- Labor Relations;
- Accounting;
- Budgeting;
- Information Technology; and
- General Office Support.

MANAGED MENTAL HEALTH CARE IN CALIFORNIA

Over the past decade, there has been a move nationally to change the orientation of health care from the delivery of episodic treatment of illness to the planned provision of primary care, and other necessary services, in an integrated, coordinated system of service delivery. This coordinated system of care is known as managed care. Managed mental health care for California's Medi-Cal program is administered through a single managed care mental health plan (MHP) in each county. California's managed mental health care program served an estimated 428,5000 Medi-Cal eligibles in FY 2003-04, which represents about 64 percent of the total persons served by county mental health programs.

Ombudsman Office

The purpose of DMH's Ombudsman Office is to create a bridge between the mental health managed care system and beneficiaries receiving Medi-Cal by providing information and assistance to help them navigate the system. There are several local resources, including the patients' rights advocate and Mental Health Plan problem resolution staff, to which beneficiaries can turn for help. However, the consensus among planners and advocates is that the DMH-administered toll-free number for the DMH Ombudsman Services continues to be an important option for clients who may fall between the cracks when looking for assistance. The Ombudsman phone line is well utilized, receiving an average of 300 calls a month in SFY 2004-05.

External Quality Review Organization

The DMH has contracted with APS HealthCare to be its External Quality Review Organization (EQRO). The purpose of the EQRO is to objectively assess quality, outcomes, timeliness of and access to the services provided by 56 California Mental Health Plans (MHPs) that contract with DMH to provide Medi-Cal specialty mental health services to Medi-Cal eligible individuals.

To make this assessment of each MHP, the EQRO will conduct annual external quality reviews that include:

- Assessment of DMH-specified Performance Measures (PMs);
- Assessment of MHP-selected Performance Improvement Projects (PIPs);
- Periodic evaluation of selected aspects of each MHP's on-going internal Quality Improvement (QI) system and annual review of each MHP's progress on any related plans of correction;
- Review of each MHP's health information system capability to meet the requirements of the Medi-Cal specialty mental health services program; and
- Review of each MHP's most recent compliance review performed by the DMH Program Compliance Division, Medi-Cal Oversight Unit, and each MHP's progress on any related plans of correction.

The EQRO will prepare a report annually on each MHP that comprehensively assesses the overall performance of the MHP in providing mental health services to Medi-Cal beneficiaries. The individual MHP reports will utilize the EQRO's own assessment of each MHP in light of the review components described above. The EQRO will also prepare an aggregate report for the State based on the information gained in the assessments of the individual MHPs.

The EQRO will provide up to four hours of technical assistance and consultation for each MHP annually. The intent of this activity to meet the individualized quality improvement needs of each MHP and to maximize the utility of the external review activity as a quality improvement learning experience.

Because of the unique nature of the Medi-Cal managed mental health care system, calculation of performance measures is done by DMH using claims data obtained from the MHPs. Thus, in order to fully assess MHP performance, the EQRO will review and assess various DMH data systems and processes in addition to the MHPs' system for reporting claims data. The EQRO will prepare an annual report that comprehensively assesses the overall performance of DMH in this capacity.

The first year of reviews for SFY 2004-05 have been completed and the EQRO has utilized protocols for validation of performance measures and performance improvement projects and an information system assessment instrument developed by DMH, in addition to any review protocols or instruments developed by the EQRO for use in other areas of the review. In the second year, the EQRO will work with DMH, MHPs and other stakeholders to edit the DMH-developed protocols and information system assessment instrument as necessary to maximize their effectiveness in collecting pertinent information to meet regulatory requirements and adapt their content to the California public mental health system.

BRIEF DESCRIPTION OF SERVICES AND RESOURCES

California provides a broad array of mental health services to its residents. As specified in Section 5600.4 of the Welfare and Institutions Code (WIC), community mental health services are organized to provide an array of treatment options, to the extent resources are available, in the following areas:

- **Pre-crisis and Crisis Services**. Immediate response to individuals in pre-crisis and crisis, and to members of the individual's support system. The focus of pre-crisis services is to offer ideas and strategies to improve the person's situation, and help access what is needed to avoid crisis. The focus of crisis services is stabilization and crisis resolution, assessment of precipitating and attending factors, and recommendations for meeting identified needs. Crisis services may be provided offsite through mobile services.

- **Comprehensive Evaluation and Assessment**. Includes evaluation and assessment of physical and mental health, income support, housing, vocational training and employment, and social support needs. Evaluation and assessment may be provided offsite through mobile services.

- **Individual Service Plan**. Identification of the short- and long-term service needs of the individual, advocating for, and coordinating the provision of these services. The development of the plan is to include the participation of the client, family, friends, and providers of services to the client, as appropriate.

- **Medication Education and Management**. Includes, but is not limited to, evaluation of the need for administration of, and education about, the risks and benefits associated with medication. Clients are to be provided this information prior to the administration of medications pursuant to State law. To the extent practicable, and as authorized by the adult client, families and caregivers should also be informed about medications.

- **Case Management**. Client-specific services that assist clients in gaining access to needed medical, social, educational, and other services. Case management may be provided offsite through mobile services.

- **Twenty-four Hour Treatment Services**. Treatment provided in any of the following: an acute psychiatric hospital; an acute psychiatric unit of a general acute care hospital; a psychiatric health facility; a nursing facility; an institution for mental disease; or community residential treatment programs, including crisis, transitional and long-term programs.

- **Rehabilitation and Support Services**. Treatment and rehabilitation services designed to stabilize symptoms, as necessary, to live in the community. These services may be provided through various modes of services, including, but not limited to, individual and group counseling, day treatment programs, collateral contacts with friends and family, and peer counseling programs. These services may be provided offsite through mobile services.

- **Vocational Rehabilitation**. Services that include a range of vocational services to assist individuals to prepare for, obtain, and maintain employment.

- **Residential Services**. Room and board and 24-hour care and supervision.

- **Services for Persons Who Are Homeless**. Services designed to assist persons who have a mental illness and are homeless, or who have a mental illness and are at risk of being homeless, to secure housing and financial resources.

- **Group Services**. Mental health services to two or more clients at the same time as articulated above.

SIGNIFICANT ACHIEVEMENTS IN AREAS NEEDING ATTENTION/ NEW DEVELOPMENTS AND ISSUES

CalMEND

CalMEND is a consumer focused, evidence driven effort to develop and implement a statewide mental health care management program that improves health outcomes and promotes recovery of clients with serious mental illness. CalMEND is jointly undertaken by the Department of Health Services (DHS) and the Department of Mental Health (DMH) in collaboration with state agencies, county mental health plans, consumer and family members, and the University of California Medical Centers. All activities and program components developed will be consistent with the Mental Health Services Act goals and objectives, philosophies, practices, and performance measurement standards.

Seclusion and Behavioral Restraint Reduction Initiative

Senate Bill 130 (Chesbro), the Seclusion and Behavioral Restraint Reduction Initiative, passed in SFY 2004-05. With the passage of new laws, restrictions and data reporting requirements related to the use of seclusion and restraint, DMH's Long Term Care Services has developed and implemented enhanced recovery-oriented procedures and data collection in the State Hospital system as follows:

- Improved, person-centered initial assessment process that places a stronger focus on collaboration with the individual when developing an individualized treatment plan and identifying early intervention strategies to avoid psychiatric emergencies.

- Augments to the debriefing process (increases discussions and treatment plan modifications to avoid future need/use of seclusion or restraint).

- Modified data collection system that identifies frequency and/or duration for seclusion and behavioral restraint, the number of deaths and serious injuries to the individual and staff that may be associated with these emergency interventions, and the frequency of incidents wherein an emergency medication is administered. This data is posted quarterly on the DMH web page at www.dmh.ca.gov under "Reports".

Many other activities related to seclusion and restraint reduction are in progress and include:

- Enhancements to the State Hospital Prevention and Management of Assaultive Behavior training program.

- Development of a Personal Empowerment and Preference (PEP) plans to more effectively identify individual treatment choices and techniques that will assist individuals in controlling negative behavior.

- Ongoing efforts to research and develop new strategies towards the reduction of behavioral emergencies and the use of seclusion and restraint.

Integrated Services for Homeless Adults with SMI (AB 2034)

AB 2034 programs provide client-driven integrated, comprehensive services that support persons moving from homelessness to living independently, working, maintaining community supports, caring for their children, remaining healthy, and avoiding crime. The services provided in this program include but may not be limited to outreach, supported housing (including immediate, transitional and permanent), supported employment, mental health and medical treatment along with related medications, substance abuse, benefits assistance, and other non-medical services necessary to stabilize this population. The programs establish close collaboration at the local level among core service providers, including mental health, law enforcement, veterans' services agencies, and other community agencies.

One outcome goal of AB 2034 programs was to decrease homelessness, acute hospitalizations, and incarcerations of persons with severe mental illness. As of January 31, 2005, there were 4,626 homeless persons with serious mental illness enrolled under the AB 2034 program. The number of days of psychiatric hospitalization since enrollment dropped 63.8 percent, the number of days of incarceration dropped 76.3 percent, and the number of days spent homeless dropped 70.02 percent. Another important outcome goal of this program was to increase the number of days of employment. This year, the striking increase in the number of days of both full-time employment (55.0 percent) and part-time employment (167.5 percent) from pre-enrollment to post-enrollment demonstrate that the ongoing support that consumers experience in the AB 2034 programs is having a greater impact on their ability to maintain employment. The number of unduplicated adult consumers who engaged in educational activity from pre-enrollment to post-enrollment increased 117.9 percent.

The Mental Health Services Act (MHSA) of 2006

The passage of Proposition 63, the Mental Health Services Act (MHSA) in November 2004, provides an opportunity to increase funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for serving children, transition age youth, adults, older adults and families with mental health needs. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system. The MHSA specifies

six major components around which DMH has created an extensive stakeholder process to consider input from all perspectives (see the section on State Priorities and Plans to Address Unmet Needs for a more detailed overview of the MHSA).

LEGISLATIVE INITIATIVES

None at this time.

LOCAL MENTAL HEALTH BOARDS/COMMISSIONS

As stated in WIC, Division 5, Section 5604, each county shall establish its own local mental health board/commission. The board/commission members are appointed by the Board of Supervisors and 50 percent of the membership must be direct clients or their families.
The duties of the local mental health board are as follows:

- Review and evaluate the community's mental health needs, services, facilities, and problems;
- Review any county agreements entered into pursuant to California's WIC, Section 5650;
- Advise the county board of supervisors and the local mental health director as to any aspect of the local mental health program;
- Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process;
- Submit an annual report to the Board of Supervisors on the needs and performance of the county's mental health system;
- Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the Board of Supervisors;
- Review and comment on the county's performance data and communicate its findings to CMHPC;
- Perform other duties and responsibilities as specified by the Board of Supervisors; and
- Assess the impact of realignment on clients and the local community.

CALIFORNIA MENTAL HEALTH DIRECTORS ASSOCIATION

The California Mental Health Directors Association (CMHDA) is a dues-supported membership association comprised of the directors of county and city mental health systems throughout California.

The Association provides public policy development and advocacy services for the directors who are responsible for providing mental health services to children, transition-age youth, adults and older adults with mental illness in California's public mental health system.

The CMHDA has a structured system of governance. The Association conducts monthly one-day statewide meetings, as well as two statewide Mental Health Policy Forum meetings annually to keep the public mental health system informed about policy developments and advances or changes in clinical best practice approaches.

In addition, the Association maintains a system of committees, some of which include membership beyond the directors, including clients, family members, and service provider representatives. These committees are organized around age-specific services, i.e., Adult, Children's and Older Adult Systems of Care, as well as Medi-Cal policy, medical services, information technology and financial services. Lastly, CMHDA plays an essential role in developing and implementing public mental health services, in partnership with the State Department of Mental Health (DMH) and other mental health advocacy groups.

The CMHDA also advocates with the California State Legislature and Administration on issues of importance to California's county and city mental health agencies, and the clients they serve.

The public mental health system in California has recently been given a tremendous new opportunity, through the passage of Proposition 63 - the Mental Health Services Act (MHSA) - to significantly improve and expand services. For the past few years there has been a tremendous and growing need for publicly funded mental health services for children with serious emotional disturbance (SED) and adults and older adults with serious mental illness, at the same time that resources at the state and county levels have remained stable or even decreased. The current unmet need for public mental health services is significant, and is growing daily. The MHSA will give counties a much-needed opportunity to address that unmet need, with a vision of recovery and healthy development for every individual served. CMHDA has been and will continue to be actively involved in the implementation of this Act.

Other specific CMHDA policy priorities are:

Funding:

- Protect mental health funding from supplantation efforts at the state and local levels to ensure compliance with the spirit and intent of the MHSA.
- Support full retroactive and prospective reimbursement of costs incurred by county mental health departments for providing eligible mental health treatment services to Special Education Program (SEP) pupils (AB 3632).
- Seek legislative/regulatory resolution to the billing problems related to payment for medications under the Healthy Families program for SED children.
- Protect against legislative efforts to impose additional mandates on county mental health departments absent full funding and administrative flexibility.
- Protect Realignment funding, including VLF resources, and analyze the impact of growth formulas on mental health funding.

- Advocate for administrative relief from unnecessary or duplicative state and federal regulations.
- Protect existing state resources to offset the substantial costs to counties of compliance with new federal managed care regulations.

Mental Health Program Improvement & Expansion Efforts:

- Monitor and collaborate with other stakeholders regarding necessary legislative clarification of the MHSA.
- Support county mental health directors in their efforts to coordinate and respond to program elements of the MHSA.
- Strengthen and expand systems of care funding and programs, including programs for mentally ill homeless persons.
- Continue to seek additional funding opportunities for supportive housing for individuals with mental illness.
- Support cultural competency legislation in the health and human service field.

Clinical Management Efforts:

- Monitor implementation of Therapeutic Behavioral Services.
- Monitor legislation related to the use of anti-depressants.
- Work collaboratively with the state Department of Mental Health and other state and local agencies to implement HIPAA.
- Support state enforcement of private health plan mental health insurance parity laws.
- Support mental health and substance abuse treatment parity legislation at the federal level.
- Support policies that make the mental health and alcohol and drug treatment systems better able to provide treatment to individuals with co-occurring disorders.
- Monitor and support state and federal legislation related to Medicare Part D coverage for persons with serious mental illness.
- Monitor and support legislation that allows counties to purchase psychotropic medications at lower costs.
- Monitor federal and state legislation related to Medicaid (Medi-Cal) Redesign.

Mental Health Training & Education Efforts:

- Work collaboratively with other local and state agencies and organizations on issues of mutual concern (e.g. child welfare redesign).
- Support efforts to increase the recruitment and training of the public mental health workforce.

Section II: Identification and Analysis of the Service System's Strengths, Needs and Priorities

STRENGTHS AND WEAKNESSES OF THE ADULT AND CHILDREN'S SERVICE SYSTEM

The strength of California's mental health system lies in its goal of delivering culturally competent, client-directed recovery services delivery system with local advocacy and program implementation at the county level. California's mental health system maintains a strong commitment to ensure that consumer and family involvement is an overriding value in planning, implementation, and oversight.

California has demonstrated that with effective treatment and support, recovery from mental illness is feasible for most people. California has developed effective models of providing services to children with serious emotional disturbance, and adults and older adults with serious mental illness (SMI). One such innovative approach, the Integrated Services for Homeless Adults with SMI program, was recognized in 2003 as a model program by the President's New Freedom Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the State for years to come. Other innovative programs address services to underserved populations such as traumatized youth and isolated seniors. These successful programs emphasize client-centered, family- focused, and community-based services that are culturally and linguistically competent and are provided in an integrated services system.

ANALYSIS OF UNMET SERVICE NEEDS, CRITICAL GAPS AND DATA SOURCES

The President's New Freedom Commission on Mental Health revealed that in our nation one out of every two persons who needs mental health treatment does not receive it. In addition, in its report titled *California Mental Health Master Plan: A Vision for California*, the California Mental Health Planning Council states that "a crisis also exists in access to mental health care for persons who are indigent…the availability of services for indigents has only gotten worse."

The report further states that "this unmet need for mental health services and crisis in access to services is brought into focus when one considers the advancements that have been made in understanding the nature of mental illness over the last two decades. Many effective treatments, both in terms of medication and psychosocial rehabilitation, have been found for major mental illnesses. Innovative programs, such as wrap-around programs and strength-based, family- focused treatment planning, have brought breakthroughs in services to children and their families."

STATE'S PRIORITIES AND PLANS TO ADDRESS UNMET NEEDS

The passage of Proposition 63, the Mental Health Services Act (MHSA) in November 2004, provides an opportunity to increase funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for serving children, transition age youth, adults, older adults and families with mental health needs. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system.

The purpose of the MHSA is to:

- Define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care;

- Reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness;

- Expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations;

- Provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure; and,

- Ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices, subject to local and state oversight, to ensure accountability to taxpayers and to the public.

THE MENTAL HEALTH SERVICES ACT (MHSA) OF 2006

The passage of Proposition 63, the Mental Health Services Act (MHSA) in November 2004, provides an opportunity to increase funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for serving children, transition age youth, adults, older adults and families with mental health needs. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system.

The MHSA specifies six major components around which DMH has created an extensive stakeholder process to consider input from all perspectives. Because of the complexity of each component, implementation of the six components is being staggered. The stakeholder process involves the development of discussion documents, a series of general stakeholder meetings and topic-specific workgroups to provide input on critical issues, and to advise on implementation policies and processes. To date the

State has convened 19 general and workgroup-specific stakeholders meetings and 16 conference calls. More than 4,800 emails have been generated to the general MHSA email address, 140 calls to the toll-free phone line and in excess of 89,000 visits to the MHSA Website.

Each component of the MHSA addresses critical needs and priorities to improve access to effective, comprehensive, culturally and linguistically competent expanded county mental health services and supports. Improvement in client outcomes is a fundamental expectation throughout the implementation process. The six components are:

- **Community Program Planning Process**—This is an inclusive local process involving clients, families, caregivers, and partner agencies to identify community issues related to mental illness and resulting from lack of community services and supports. It also defines the populations to be served and the strategies that will be effective for providing the services, to assess capacity, and to develop the work plan and funding requests necessary to effectively deliver the needed services.

  Since passage of the Mental Health Services Act in November 2004, the Department of Mental Health has initiated an extensive transparent stakeholder process, beginning with its first general stakeholders meeting held in December 2004. The State convened 17 general and workgroup-specific stakeholders meetings and 15 conference calls. There have been 3,822 emails generated to the general MHSA email address, 104 calls to the toll-free phone line and more than 55,000 visits to the MHSA Website. Additional accomplishments include development of the Department's guiding principles to assist the implementation of the Community Services and Supports component, issuance of five MHSA-specific DMH Policy Letters, development and distribution of the MHSA Community Services and Supports Three-Year Program and Expenditure Plan Requirements, and development of detailed funding principles, including funding for Community Program Planning and one-time funding.

  Beginning in February 2005, counties began submitting plans to initiate the MHSA Community Program Planning Process. Plan requirements for Community Services and Supports were developed and made available for stakeholder review and comment. Counties were requested to submit a Funding Request to DMH in order to receive MHSA funding to develop their local Community Program Planning process. DMH staff provided technical assistance to facilitate the planning processes. Approximately $12.7 million was distributed to counties for planning of the MHSA Community Services and Supports component.

- **Community Services and Supports (CSS)**—"System of Care Services" described in the MHSA is now called "Community Services and Supports." The CSS are the programs, services, and strategies that are being identified by each county through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating racial disparity. The DMH developed plan requirements for the Program and Expenditure Plan for Community Services and Supports with

stakeholder participation in early 2005 and released them in final August 1, 2005. No specific due date was provided for counties to submit their Program and Expenditure Plan. To date 47 county plans have been received and have either been approved or are in the process of approval. Twenty four county plans have been approved for funding.

- **Education and Training**— In the Education and Training component, the MHSA specifies that each county mental health program shall submit to the Department a needs assessment identifying shortages in each professional and other occupational category and a plan to increase the supply of professional and other staff that county mental health programs anticipate they will require. The California Mental Health Planning Council is statutorily mandated to advise the State Department of Mental Health on education and training policy development and provide oversight for the department's education and training plan development.

  DMH is required to identify the total statewide needs for each professional and other occupational category and develop a five-year education and training development plan. That plan is to reviewed and approved by the California Mental Health Planning Council.

  In partnership with its stakeholders, DMH has began development of a work plan to complete the required statewide needs assessment and develop a five-year education and training development plan. This will include building a staff and budget structure to fund the statewide and county programs that will address the Education and Training outcomes that are stipulated in the Act. DMH has begun the process of obtaining stakeholder input to initial drafts of the five-year plan structure and needs assessment methodology

- **Capital and Information Technology**— The Mental Health Services Act (MHSA) specifies that a portion of the MHSA funds may be used for capital facilities and technological needs to support community-based integrated service experiences for clients and their family members, consistent with the county's Community Services and Supports Program and Expenditure Plan. Capital facilities may include housing and other buildings that enable mental health clients and their family members to live in the most independent, least restrictive housing possible in their local community and to receive services in community-based settings that support wellness, recovery and resiliency. Decisions about how to use the MHSA funds available for capital expenditures must be guided by the overarching transformation goal. The Department is fully vetted and actively involved in a public stakeholders process to solicit input on ideas for effective use of MHSA Capital Facilities funds. No decisions regarding implementation of plans for Capital Facilities funding will be made until all stakeholder input is considered.

  The purpose of the Information Technology (IT) component of the MHSA is to design a flexible and comprehensive data system that includes the electronic capture of mental health information. This standardized process will reduce data reporting

redundancy by integrating client and services information, health record information, outcomes information, etc. into a centralized system for enhanced outcomes reporting. The long-term IT vision will result in a standard electronic health record, which is also a national goal.

- **Prevention and Early Intervention**—The MHSA authorizes the Department to establish a program designed to prevent mental illness from becoming severe and disabling. DMH has the responsibility to develop the program requirements and then review three-year Prevention and Early Intervention proposals submitted by the counties. Once the DMH has reviewed the county requests, programs will be referred to the Mental Health Services Oversight and Accountability Commission (MHSOAC) which has responsibility to review and approve each county mental health program for expenditures pursuant to Parts 3.2 for Innovative Programs and Part 3.6 for Prevention and Early Intervention. DMH will provide technical assistance to the counties as needed to address concerns or recommendations of the MHSOAC.

- **Innovation**—The goal of this component is to develop and implement promising and proven practices designed to increase access to services by underserved groups, increase the quality of services and improve outcomes, and to promote interagency collaboration. The Department has the responsibility to review local plans for Innovation. The MHSOAC has the primary responsibility for approving the plans. The Department will work in concert with the MHSOAC to ensure consistency between the plan for Innovation and the CSS Program and Expenditure Plans.

MHSA Related Activities

Outcome Reporting

The DMH will measure performance with respect to the MHSA on three levels, (1) the individual client level, (2) the mental health program/system accountability level, and (3) the public/community-impact level.

The DMH envisions the development of standard performance indicators, as well as standards for their measurement and reporting. A dynamic, responsive system for data capture at the county mental health service provider level will be coupled with an integrated, centralized process of accessing up-to-date county information. The department plans to initiate in January 2006, and annually update, a phased, long-term statewide technology design for mental health care transformation. The first phase is the development of a system that captures the data required to report on the effectiveness of the new MHSA services. This information will initially be used to show the increase in access to services, expansion in the number of clients served, and improvement during "key events" in the client's status, such as living arrangement, education, hospitalization, etc. In addition to services tracking, DMH must also incorporate a data capture process for reporting of MHSA performance at the community or public impact level in the first phase.

The DMH initiated the Performance Measurement Advisory Committee (PMAC) in September 2005 in response to MHSA performance measurement needs. The purpose of the Committee is to provide consultation and advice on the performance measurement design, development and implementation for the MHSA, and to integrate MHSA performance measurement processes into an overall performance measurement system for mental health system accountability. The PMAC, with a membership of twenty individuals representing the diverse persons and geographic areas within California, convened twice, once in September and again in October 2005. Based on the AB 2034 model, the PMAC developed initial requirements for measuring individual-level performance outcomes for Full Service Partnerships (FSPs). Three types of assessments were developed for the age groups specified in the *Mental Health Services Act Community Services and Supports, Three-Year Program and Expenditure Plan Requirements, Fiscal Years 2005-06, 2006-07, 2007-08* document, including children/youth (0-15 years), transition age youth (16-25 years), adults (26-59 years), and older adults (60+ years). A Web-based data entry system has been implemented which will allow counties to submit their data electronically.

Training

The MHSA requires the DMH to conduct an extensive stakeholder process throughout planning and implementation and to educate and train the county mental health departments. Due to the aggressive timeline for conducting this process, it was critical that consultants with extensive background and knowledge of the DMH and county mental health program issues assist with the development of training principles and products. DMH issued a contract to the California Institute for Mental Health (CIMH) (approximately $500,000), as they have this level of expertise and collaborative working relationship with the local county mental health departments. CIMH is providing a series of regional trainings, video-conferences, data trainings, Web-casts and targeted county specific site-based trainings. These trainings targeted county staff, stakeholders, and contract providers responsible for implementing the MHSA. Training topics included how to conduct an effective stakeholder process, how to prepare the Community Services and Supports plan, informational sessions on wellness, recovery, client and peer-run services, employment and strategies for outreach and engagement of the unserved mental health populations.

During this past year CIMH has provided 45 trainings reaching more than 1,400 participants and 52 county mental health departments. The outcome of these trainings resulted in counties engaging in an extensive community planning process, working toward transforming their local systems to meet their specific community needs.

Short-Term Strategies

There was significant interest in the State beginning implementation of some aspects of the MHSA prior to completion of the local planning processes. The criteria used for considering these short-term strategies were consistency with the vision of the MHSA

and consensus among stakeholders that early implementation is advisable. Short-term strategies funded by the Department from state support funds during FY 2005-06 include:

• **Network of Care** ($2.4 million for system development of county specific Web-based tools and one year maintenance for all counties) – Network of Care is a Web-based tool that provides access to a wide range of information and referral services, references, case management, etc. and that can be customized for each county and each disability group. Network of Care was previously implemented by five counties for mental health services and is widely touted in those communities. The California-developed Web design has been replicated in many other states and was highlighted as a model program by the President's New Freedom Commission on Mental Health. As a result of the MHSA, this program was expanded statewide and is now fully operational.

• **California Social Work Education Center (CalSWEC)** ($5.8 million to provide stipends to educate 206 graduate students with a commitment to work in the mental health system) – The MHSA emphasizes the need for increasing the numbers and diversity of professionals in the mental health workforce. One of the strategies the Department is pursuing toward this effort is to fund a proposal submitted by the California Social Work Education Center (CalSWEC). CalSWEC administers a program providing stipends to ethnically diverse students who have a commitment to working in public mental health and requiring that the schools of social work adopt mental health competencies. The Education and Training component of the MHSA specifically states that such a program be developed in the Education and Training five-year plan. CalSWEC has developed a strategy that is a realistic first step in establishing pragmatic approaches to expand the capacity of the workforce. The program provides $18,000 stipends for up to 206 graduate students during the 2005-2006 school year in exchange for a commitment to work in the public mental health system.

• **Collaborative Constituency Training** ($150,000 for eight county outreach and educational forums to be held in selected counties throughout the State, designed to increase awareness of the MHSA in under-represented communities and organizations) – DMH is collaborating with major constituency organizations in the mental health field to outreach to broad and diverse client/family member populations. To this end, DMH has contracted with the Constituency Outreach and Education Collaborative (COEC), which is comprised of the four major client/family organizations: the California Network of Mental Health Clients (CNMHC), the Mental Health Association in California, (MHAC), the National Alliance for the Mentally Ill (NAMI-CA), and United Advocates for Children of California (UACC). Each of these organizations has a statewide network in place to reach client/family stakeholders and extensive involvement in outreach efforts. They are jointly providing outreach, support, education and training services to under-represented communities to broaden the participation in state and local MHSA planning and implementation.

Governor's Homeless Initiative

The Governor's Homeless Initiative (GHI) creates a housing finance model that ties together California Housing Finance Agency (CalHFA) debt financing, tax credits, capital subsidies (Proposition 46) and MHSA funds to encourage development of supportive housing projects that target chronically homeless individuals with serious mental illness. This Initiative offers a non-traditional centralized loan and application approval process. Approximately $3.15 million from MHSA funds in FY 2005-06 are targeted for this initiative, with $2 million designated for rental subsidies, $750,000 designated for pre-development costs, and $400,000 distributed to establish supportive housing development collaboration at the local level. The focus of the efforts at the local level has begun with the implementation of DMH sponsored Regional Housing Trainings being conducted throughout the State. The goal for these trainings is to bring together county mental health departments, county housing agencies, housing developers, and community-based service providers to share expertise and leverage resources to develop more housing opportunities for homeless people with serious mental illness. County mental health departments are a fundamental component of this collaborative effort, and they are required to provide a long-term commitment to fund supportive services for a project to qualify for approval under this collaborative initiative.

MHSA Housing Initiative

On May 12, 2006, Governor Schwarzenegger issued Executive Order S-07-06 to continue the interagency collaboration established through the Governor's Homeless Initiative by designating up to $75 million in existing Mental Health Services Act (MHSA) funding each year to develop and build housing for individuals with mental illness, and their families, who are chronically homeless. It is anticipated that these MHSA resources will be leveraged to secure an estimated $4.5 billion in other funding sources and would enable the construction of over 10,000 new housing units. As a condition of receiving funds, county mental health departments are required to provide the supportive services necessary to maintain these individuals in their homes. This blend of safe, affordable housing with accessible supportive services is essential for homeless individuals with serious mental illness to stabilize their health and live and work in our communities.

Oversight and Accountability Commission

As specified in the MHSA, the Mental Health Services Oversight and Accountability Commission (MHSOAC) was established in June 2005. The MHSOAC will oversee implementation of the Children's, Adults and Older Adults Services, Education and Training, Innovative Programs, and Prevention and Early Intervention components of the MHSA. Upon the appointment of its sixteen members, the MHSOAC held its first meeting in July 2005. The MHSOAC recruited for its Executive Director. The selected candidate will be announced in early 2006. At that time, the MHSOAC will initiate

recruitment efforts for its remaining staff. Committees corresponding to each component of the MHSA are currently in the process of appointment.

RECENT SIGNIFICANT ACHIEVEMENTS

Current Changes to Practices Regarding Hospitalization

Long Term Care Services (LTCS) maintains its commitment to excellence in the provision of services to the mentally ill. To that end we have instituted a number of changes based upon best practices. Quality assurance reviews continue to yield valuable results that are reflected in our approach to services.

Among the changes in progress or already enacted are the development and implementation of policies and procedures based on a recovery model of mental health care that provides effective treatment consistent with generally accepted evidence-based practices of care. These include a person-centered, strength-based, holistic, and recovery-focused assessment and treatment planning system that is based on assessed needs of the individual child or adolescent. Treatment teams review and revise, as appropriate, treatment plans and evidence-based interventions for each patient on a specified schedule based on assessed treatment outcomes.

LTCS continues to implement policies and procedures to eliminate the use of seclusion and physical restraints, and these interventions will be reserved only for emergency use for safety of self, peers, and staff. We are creating a general physical environment and therapeutic milieu for treatment that is consistent with our values. This includes developing and implementing plans for enhancing supports and services that will enable patients to be discharged as soon as their mental health and legal issues have been resolved so they can be in a less restrictive level of care. This is being achieved by training staff to provide effective, positive interventions in a kind, caring, and compassionate manner to all in their care. Each discipline has specific targets to ensure better care. Psychiatrists need to assess, diagnose and prescribe medication based on a rational pharmacologic approach integrating information and feedback about psych-social and educational issues. Pharmacists are expected to play a more visible role in medication issues. Psychologists are expected to assess the need for and provide behavior therapy based on a positive behavior supports model and cognitive behavior therapy for the emotional and behavioral disorders experienced by the patients in their care.

All of our standards and operational processes are being reviewed and amended to ensure that patients at the state hospitals receive the most beneficial treatment possible in a setting that is committed and conducive to patients achieving the highest possible level of functioning in the shortest possible time.

Institutions for Mental Disease (IMD) Transition Grant Program

DMH provided funding to implement two pilot programs that focused on developing strategies and processes that support transitioning individuals from IMDs into community living situations. State General Funds were awarded to Merced County and San Francisco County for two fiscal years (SFY 2002-03 and SFY 2003-04) in the amount of $640,000 for each year. The primary target population for the San Francisco County Project is African-American men. This focus is based on an internal study that was completed by the San Francisco County Mental Health Department that demonstrated that a disproportionate number of African-American males are in IMDs. The study also revealed that these men stay longer, recidivate faster, and it is more difficult to locate housing for them in the community. Based on this information, San Francisco developed an Afro-centric IMD transition program called the Alternatives Program. The services in this program were developed to be culturally meaningful to these men, and the project has successfully created a place where consumers feel comfortable, respected, and receive a range of supportive services. The Merced County IMD transition project is utilizing peer support and mentoring as an integral component of helping individuals establish a life in the community. This project has also worked to strengthen both community and social resources that support independence as well as social connection.

DMH also awarded approximately $60,000 for a broader statewide evaluation of IMD usage. This evaluation project is focused on the current use of IMDs in California as well as generating recommendations for effective strategies for community placement and alternatives to IMDs. The evaluation will identify "best practice" models that could be replicated statewide. The final evaluation report was submitted October 2005.

Both of these efforts are intended to provide information relevant to California's long-term care planning strategies. The experience and information gathered is a valuable effort toward further compliance with the federal Olmstead decision for individuals with serious mental illness.

Co-Occurring Joint Action Council

The Department of Alcohol and Drug Programs (ADP) and DMH have long recognized the critical need of working cooperatively to provide quality treatment services to individuals with co-occurring disorders. Building on the efforts that have taken place since 1995, DMH and ADP, in collaboration with the County Alcohol and Drug Program Administrators Association of California, the California Mental Health Directors Association, the Alcohol and Drug Program Institute, and the California Institute for Mental Health, convened the Co-Occurring Joint Action Council, which meets quarterly.

The Council's vision statement — "One Team with One Plan for One Person" — states that "Each individual receives a comprehensive assessment that results in the formation of an interdisciplinary and possibly interagency team that will develop one individualized treatment plan for that person within a reasonable period of time. This plan will specify all necessary services and supports to be delivered by the single interdisciplinary

service team that has all the needed skill sets and the right members in place from each agency. The individual client will have a strong voice in shaping the plan in development and implementation. The plan is expected to evolve as needed as that person progresses."

PUBLIC MENTAL HEALTH SYSTEM ENVISIONED FOR THE FUTURE

The DMH, in unison with its employees, clients, families, and business partners, embrace the following vision and core values of California's public mental health system where all of our customers' needs are met:

- Clients live, work and learn in their community in the least restrictive setting;
- The community is safe and industrious;
- Relationships are primary among employees, clients, families, and business partners;
- Cultural diversity is appreciated as a source of strength and balance;
- Society is aware of and appreciates the realities of mental illness;
- Success is determined through evidence- and performance-based outcomes;
- The DMH meets challenges through partnerships, creativity, flexibility, innovation and
  Research;
- Client and family needs drive the creation of public policy; and
- Everyone takes responsibility for continuous quality improvement of the mental health System.

California Department of Mental Health (DMH)
Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act

Introduction

The Mental Health Services Act (MHSA) includes a clear set of challenging goals for all stakeholders to hold in common as the MHSA becomes reality. Within the context of those common goals, the California Department of Mental Health (DMH) developed, in partnership with stakeholders, a ***Vision Statement*** and ***Guiding Principles*** to use as it implements the Community Services and Supports component of the MHSA.

Most of the language and concepts included in the Vision Statement and Guiding Principles document were originally presented to MHSA stakeholders on the DMH website and at a public meeting in Sacramento in December 2004. At that time it was

entitled “DMH Vision Statement”. Since then, in response to stakeholder comments and DMH policy clarification, this document has become a Vision Statement and Guiding Principles for DMH to hold for itself and stakeholders as it implements the Community Services and Supports component of the MHSA.

As a designated partner in this critical and historic undertaking, the California Department of Mental Health (DMH) will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA DMH pledges to look beyond “business as usual” to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists.

Beyond the goals in statute for the MHSA as a whole, DMH has developed, with stakeholder input, a set of Guiding Principles. These Guiding Principles will be the benchmark for DMH in its implementation of the MHSA Community Services and Supports component. DMH will work toward significant changes in the existing public mental health system in the following areas:

Consumer and Family Participation and Involvement

- Significant increases in the level of participation and involvement of clients and families in all aspects of the public mental health system including but not limited to: planning, policy development, service delivery, and evaluation.

- Increases in consumer-operated services such as drop-in centers, peer support programs, warm lines, crisis services, case management programs, self-help groups, family partnerships, parent/family education, and consumer provided training and advocacy services.

- Full implementation of an approach to services through which each client and her/his family, as appropriate, participates in the development of an individualized plan of services determined by the individual’s goals, strengths, needs, race, culture, concerns and motivations.

Programs and Services

- Changes in access and increased geographic proximity of services so that clients will be able to receive individualized, personalized responses to their needs within a reasonable period of time and to the extent needed to enable them to live successfully in the community.

- Elimination of service policies and practices that are not effective in helping clients achieve their goals. Ineffective treatment methods will be replaced by the

development and expansion of new values-driven, evidence-based and promising practices, policies, approaches, processes and treatments which are sensitive and responsive to clients' cultures and produce more favorable outcomes.

- Increases in the array and types of available services so children, transition age youth, adult and older adults clients and their families will be able to choose, in consultation with mental health professionals, the kinds of services and the intensity of services that will assist them in attaining the goals in their individualized plans.

- Integrated treatment for persons with dual diagnoses, particularly serious mental illness and serious substance use disorders, through a single individualized plan, and integrated screening and assessment at all points of entry into the service system.

Age–Specific Needs

- For children, youth and their families, implementation of specific strategies to achieve more meaningful collaboration with child welfare, juvenile justice, education and primary healthcare, in order to provide comprehensive services designed to enable youth to be safe, to live at home, to attend and succeed in school, abide by the law, be healthy and have meaningful relationships with their peers.

- For transition-age youth, programming to address the unique issues of this population who must manage their mental health issues while moving toward independence. This should include a person as a point of contact who would follow youth as they transition from the youth systems into the adult system or move out of the mental health system. To meet the needs of these youth, programming needs to include specific strategies for collaboration between the youth and adult systems of care, education, employment and training agencies, alternative living situations and housing and redevelopment departments.

- For adults, implementation of specific strategies to achieve more meaningful collaboration with local resources such as physical health, housing, employment, education, law enforcement and criminal justice systems in order to promote creative and innovative ways to provide integrated services with the goals of adequate health care, independent living and self-sufficiency.
- For older adults, implementation of specific strategies to increase access to services such as transportation, mobile and home-based services, comprehensive psychiatric assessments which include a physical and psychosocial evaluation, service coordination with medical and social service providers and integration of mental health with primary care. The ability to reside in their community of choice is a fundamental objective.

- For all ages, reductions in the negative effects of untreated mental illness including reductions in institutionalization, homelessness, incarceration, suicide, and unemployment.

Community Partnerships

- Significant increases in the numbers of agencies, employers, community based organizations and schools that recognize and participate in the creation of opportunities for education, jobs, housing, social relationships and meaningful contributions to community life for all, including persons with mental illness. Care must be collaborative and integrated, not fragmented.

Cultural Competence

- Outreach to and expansion of services to client populations to more adequately reflect the prevalence estimates and the race and ethnic diversity within counties and to eliminate disparities in accessibility and availability of mental health services.

- Implementation of more culturally and linguistically competent assessments and services that are responsive to a client's and family's culture, race, ethnicity, age, gender, sexual orientation and religious/spiritual beliefs.

Outcomes and Accountability

- Expanded commitment to outcome monitoring including developing/refining strategies for evaluation of consumer outcomes, and system and community indicators, using standardized measurement approaches whenever possible. Data needs to be readily accessible and viewed as an essential part of program planning.

- Development and implementation of policy and procedures to ensure that changes in service array in the future are based on intended outcomes. This may necessitate increased training and support for the mental health workforce.

- Achievement of the MHSA accountability goals necessitates statewide adoption of consistent, effective service delivery approaches as well as standard performance indicators, data measurement and reporting strategies.

Taking a Comprehensive Viewpoint

- Beyond the MHSA goals, and the DMH Vision Statement and Guiding Principles for implementation of Community Services and Supports, DMH will rely on the principles, goals, strategies, data and other information from the following nationally recognized documents and sources:

    - Principles articulated in the *President's New Freedom Commission Report* on Mental Health report.
    - Accountability based on the spirit of the Institute of Medicine's *Crossing the Quality Chasm* report.

- Accountability based on the findings of Mental Health: Culture, Race and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 2001.
- The vision, mission and values of the public mental health system as articulated in the California Mental Health Planning Council's *Master Plan*.
- DMH will also consider previous reviews of the public mental health system such as the Little Hoover Commission reports and the reports of the Select Committee of the California Legislature.

Section III - State Plan For Comprehensive Community Mental Health Services For Adults And Older Adults

CRITERIA FOR PLAN

With respect to the provision of comprehensive community mental health services for adults or older adults with a serious mental illness (SMI), the criteria regarding a plan are as follows:

CRITERION 1. COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SERVICE SYSTEMS

- **The plan provides for the establishment and implementation of an organized community-based system of care for such individuals.**

- **The plan describes health and mental health services, rehabilitation services, treatment options, employment services, housing services, educational services, medical and dental care, and other available support services to be provided to such individuals with federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.**

- **The plan provides for activities to reduce the rate of hospitalization of such individuals.**

- **The plan requires the provision of case management services to each such individual in the State who receives substantial amounts of public funds or services.**

ADULT/OLDER ADULT ORGANIZED COMMUNITY-BASED SYSTEM OF CARE

The Department of Mental Health (DMH) has presented in past plans, descriptions of activities focused upon the implementation of integrated systems of care (SOC) for children, adults and older adults. These activities include finance reform and the application of new measures of accountability, including the development of performance outcomes. The current phase of these efforts may best be characterized by their integration with each other within the domain of public human services.

Today, adult and older adult SOC efforts provide variations on recovery-based, comprehensive, and integrated service models. These service models are tailored to each client's full range of needs, as identified by the direct consumer. These needs are generally addressed within the service agency's internal array of services, and if not, are met by an outside agency with the assistance and support of the primary agency.

These models incorporate "community support program" concepts by directly involving the consumer, family members and friends as appropriate, and staff in long term planning. The array

of services includes those addressing mental health, substance abuse, education, or other needs that allow the direct consumer to become a stabilized, self-managed, and productive member of the community. An important aim is to reverse the trend of isolating and institutionalizing clients in two ways: 1) by ensuring that client priorities are met through services that are accountable on an individual outcome basis, and 2) by making the client the priority of the service, recognizing total living needs rather than addressing symptoms of mental illness only.

The SOC also incorporates the recovery model that has been described by Mark Ragins, M.D. as "the normal adaptation process that follows destruction, just like grief is the normal adaptation process that follows loss." In the field of mental health, our present description of the recovery model has four fluid stages: hope, empowerment, self-responsibility, and having a meaningful role in life. Put together as a coherent series, these stages can provide a roadmap of the process of recovery generally, and can be applied specifically to the work of helping people recover from the destruction of serious mental illness.

Characteristics of local efforts, therefore, include dedication to providing recovery-based comprehensive services, team models that rely heavily on interagency collaboration and cooperation to meet clients' needs, voluntary participation of clients in each service identified in a personal service plan, and provision of services on a 24-hour basis to meet all members' needs, including housing, supported and competitive employment, socialization, education, rehabilitation, legal assistance, money management, mental health treatment, physical health care and dental care. Some programs include strong components that provide information, counseling, respite, and other services for relatives of clients. These efforts parallel increased awareness that when mental health needs of adults are not effectively met in the mental health system, the result is usually increased costs to other human service delivery systems, including health care, substance abuse services, social services, and criminal justice.

In California, counties are largely financially responsible for human service delivery systems, and are also designated as the local mental health managed care entity, or mental health plan, for Medi-Cal beneficiaries in their geographic areas. Therefore, it is at the county and city level that adult Systems of Care development and implementation are taking place. To this end, the California Mental Health Directors Association (CMHDA) has established the Adult Systems of Care Committee to provide the structural link between DMH efforts and local efforts in establishing effective SOC for adults. The DMH continues to be well represented at the meetings of this committee and collaborates in a variety of training programs, consultations, conferences, policy formulation, and services planning associated with adult services.

Another point recognized at the local level is that effective services are usually those that are specifically designed with respect to an individual client. These services can enhance the focus on cultural, gender, and age-related issues central to understanding the individual client. Since counties and cities are the entities with the financial responsibility in California's public mental health system, SOC provide the environment in which to manage the risk presented by the serious mental illnesses of its residents.

Further, SOC must represent a coordinated service delivery structure that:

- Ensures timely and appropriate access to all of the services its members need;
- Has partnerships with clients, families, and essential agencies and organizations;
- Produces measurable outcomes and client satisfaction; and
- Enhances clinical and cost effectiveness.

Staff training in personal service planning, recovery-based service philosophy, co-occurring mental health and substance-related disorders, cultural competency, supported housing and employment, family engagement and respite services has proven invaluable in helping staff develop the skills and expertise to recognize the value of, and provide, recovery-based, comprehensive and integrated services. The DMH has expanded its training program to include consultation and technical assistance to county mental health programs and service agencies in California. Additionally, the training program, which has been enhanced and expanded through an interagency cooperative agreement with the State Department of Rehabilitation, assists county mental health programs in replicating the models described above or enhancing traditional programs by adding individual program components or service philosophy from those models.

SERVICE COORDINATION AND ACCOUNTABILITY TO THE CLIENT AND FAMILY

The DMH, in conjunction with the California Mental Health Planning Council (CMHPC), supports service coordination principles stated in the California Mental Health Master Plan. Service coordination should be viewed as "personalized helping" and as the "human link between the client and formal service delivery." This means establishing personal relationships of trust and respect, which requires developing more collaborative and respectful relationships between staff and clients.

All service coordination activities in the counties include some or all of the following elements: case-finding methods to identify clients; a comprehensive assessment of each client; a comprehensive service plan; coordination and linkage of services; provision of client advocacy to assure income protection; documentation of service delivery; money management; promotion of self-help resources; and progress reports on service plans.

MHSA

Community Services and Supports refers to "System of Care Services" as required by the MHSA. The change in terminology will differentiate MHSA Community Services and Supports from existing and previously existing System of Care programs funded at the federal, state and local levels.

The MHSA represents a comprehensive approach to the development of community based mental health services and supports for the residents of California. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. To provide for an orderly implementation of MHSA, the California Department of Mental Health has planned for sequential phases of development for each of the components. Eventually all these components

will be integrated into comprehensive plans with a continuum from prevention and early intervention to comprehensive, intensive interventions for those in need.

The first component to be implemented was the Community Planning Process. The second component will be those elements of the Act that define the requirements of service delivery to children, youth, adults and older adults with serious emotional disturbances and/or serious mental illnesses. The pertinent sections of the Act are Sections 5, 7, 10 and 15 that add or amend significant portions of the Welfare and Institutions Codes defining program requirements. County proposals will be evaluated for their contribution to meeting specific outcomes for the individuals served including:

- Meaningful use of time and capabilities, including things such as employment,
- vocational training, education, and social and community activities
- Safe and adequate housing, including safe living environments with family for children
- and youth; reduction in homelessness
- A network of supportive relationships
- Timely access to needed help, including times of crisis
- Reduction in incarceration in jails and juvenile halls
- Reduction in involuntary services, reduction in institutionalization, and reduction in out of-home placements

Plan Review Process

County mental health programs have begun submission of their Three-Year Program and Expenditure Plan for MHSA Community Services and Supports to the Department of Mental Health (DMH) to receive MHSA funding to implement this component.

Introduction to Program and Expenditure Plan Requirements

These Program and Expenditure Plan requirements are intended to build upon and operationalize the concepts in the Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act. These requirements look beyond "business as usual" and are intended to start building a system where access will be easier; services are more effective; out-of-home placements, institutional care, homelessness and incarcerations are reduced; and stigma toward those who are diagnosed with serious mental illness or serious emotional disturbance no longer exists. These requirements are intended to initiate significant changes including:

- Increases in the level of participation and involvement of clients and families in all aspects of the public mental health system
- Increases in client and family operated services
- Outreach to and expansion of services to client populations in order to eliminate ethnic disparities in accessibility, availability and appropriateness of mental health services and to more adequately reflect mental health prevalence estimates
- Increases in the array of community service options for individuals diagnosed with serious mental illness and children/youth diagnosed with serious emotional disorders,

and their families, that will allow them to avoid unnecessary institutionalization and out of-home placements

Essential Elements for All Three-Year Program and Expenditure Plans
There are five fundamental concepts inherent in the MHSA that must be embedded and continuously addressed throughout the Program and Expenditure Plans submitted by counties. These include:

- **Community collaboration**: Community collaboration refers to the process by which various stakeholders including groups of individuals or families, citizens, agencies, organizations, and businesses work together to share information and resources in order to accomplish a shared vision. Collaboration allows for shared leadership, decisions, ownership, vision, and responsibility. The goal of community collaboration is to bring members of the community together in an atmosphere of support to systematically solve existing and emerging problems that could not easily be solved by one group alone.

- **Cultural competence**: Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer providers, and family member providers to work effectively in cross-cultural situations.

  Cultural competence includes language competence and views cultural and language competent programs and services as methods for elimination of racial and ethnic mental health disparities. There is a clear focus on improved quality and effectiveness of services. Service providers understand and utilize the strengths of culture in service delivery. Culturally competent programs and services are viewed as a way to enhance the ability of the whole system to incorporate the languages and cultures of its clients into the services that provide the most effective outcomes and create cost effective programs. Identification, development, promulgation, and adoption of culturally competent best practices for care must be an integral part of ongoing culturally competent planning and implementation of the MHSA.

- **Client/family driven mental health system for older adults, adults and transition age youth and family driven system of care for children and youth:** Adult clients and families of children and youth identify their needs and preferences which lead to the services and supports that will be most effective for them. Their needs and preferences drive the policy and financing decisions that affect them. Adult services are client centered and child and youth services are family driven; with providers working in full partnership with the clients and families they serve to develop individualized, comprehensive service plans. Individualized, comprehensive service plans help overcome the problems that result from fragmented or uncoordinated services and systems.

Many adults with serious mental illness and parents of children with serious emotional disturbances1 have limited influence over the services they or their children receive. Increasing opportunities for clients and families to have greater choices over such things as types of service, providers, and how service dollars are spent, facilitates personal responsibility, creates an economic interest in obtaining and sustaining recovery, and shifts the incentives towards a system that promotes learning, self monitoring, and accountability. Increasing choice protects individuals and encourages quality. (Source: The President's New Freedom Commission on Mental Health – *Achieving the Promise Transforming Mental Health Care in America*.)

- **Wellness focus, which includes the concepts of recovery and resilience:** Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope.

  Resilience refers to the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school and in the community, mental health treatments, which teach good problem solving skills, optimism, and hope can build and enhance resilience in children.

- **Integrated service experiences for clients and their families throughout their interactions with the mental health system:** This means that services are "seamless" to clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency. Services are delivered, or at a minimum, coordinated through a single agency or a system of care. The integrated service experience centers on the individual/family, uses a strength-based approach, and includes multi-agency programs and joint planning to best address the individual/family's needs using the full range of community-based treatment, case management, and interagency system components required by children/transition age youth/adults/older adults. Integrated service experiences include attention to people of all ages who have a mental illness and who also have co-occurring disorders, including substance use problems and other chronic health conditions or disabilities. With a full range of integrated services to treat the whole person, the goals of self-sufficiency for older adults and adults and safe family living for children and youth can be reached for those who may have otherwise faced homelessness, frequent and avoidable emergency medical care or hospitalization, incarceration, out-of-home placement, or dependence on the state for years to come. These five fundamental concepts combine to ensure that through MHSA-funded activities, counties work with their communities to create culturally competent, client/family driven mental health

services and support plans which are wellness focused, which support recovery and resilience, and which offer integrated service experiences for clients and families.

Services for Adults and Older Adults: The W&I Code, Section 5813.5 specifies that MHSA services will be available to adults and seniors with severe mental illnesses who meet the eligibility criteria in the W&I Code Section 5600.3(b)—adults and older adults who have serious mental disorder and (c)—adults and older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence. Some transition age youth may also be served under these provisions.

The MHSA Program and Expenditure Plan Requirements are based on a logic model that links: (1) community issues resulting from untreated mental illness and a lack of services and supports, (2) mental health needs within the community, (3) the identification of specific populations to be served based upon the issues and needs identified, (4) the programs and services/strategies to be implemented and (5) the desired outcomes to be achieved. In addition to a focus on community issues and outcomes, the MHSA also emphasizes the importance of measuring outcomes achieved by specific individuals and families, including but not limited to: hope, personal empowerment, respect, social connections, independent living for adults and safe living with families for children/youth, self-responsibility, self determination and self esteem for clients and families. Along with other individual and system level outcomes, these individual value-driven outcomes will be incorporated within the outcome measurement system to be developed and implemented under the MHSA. DMH envisions an ongoing process of identifying community issues and unmet needs, focusing upon specific individuals and populations in need based upon these identified issues, developing and implementing state-of the-art service and support strategies and assessing outcomes: all to ensure that counties are providing the highest level of quality care possible in the most efficient and effective ways. It is further envisioned that as a part of the ongoing quality improvement process, data and feedback on the individual, community and system levels are used to refine and improve services and supports. Plans for addressing individual quality of care issues are a part of this ongoing process.

Specific Populations by Age Consistent with MHSA and DMH Priorities:

- **Children and youth between the ages of 0 and 18, or Special Education Pupils up to age 21, who have serious emotional disorders and their families, who are not currently being served**.

- **Transition age youth** between the ages of 16 and 25, who are currently unserved or underserved who have serious emotional disorders and who are homeless or at imminent risk of being homeless, youth who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems and youth involved in the criminal justice system or at risk of involuntary hospitalization or institutionalization.

- **Adults with serious mental illness** – including adults with a co-occurring substance abuse disorder and/or health condition who are either:

- **Older adults 60 years and older with serious mental illness** – including older adults with co-occurring substance abuse disorders and/or other health conditions – who are not currently being served and have a reduction in personal or community functioning, are homeless, and/or at risk of homelessness, institutionalization, nursing home care, hospitalization and emergency room services. Older adults who are so underserved that they are at risk of any of the above are also included. Transition age older adults (as described above) may be included under the older adult population when appropriate.

Each individual identified as part of the initial full service population must be offered a partnership with the county mental health program to develop an individualized services and supports plan. The services and supports plans must operationalize the five fundamental concepts identified at the beginning of this document. They must reflect community collaboration, they must be culturally competent, they must be client/family driven with a wellness/recovery/resiliency focus and they must provide an integrated service experience for the client/family.

LONG TERM CARE SERVICES

DMH's Long Term Care Services (LTCS) Division is entrusted with the administration and leadership of the California State Hospital system, the Forensic Conditional Release Program, treatment and evaluation of judicially committed offenders, the Sexual Offender Commitment Program, and additional consultation and evaluation services to State and county agencies. LTCS promotes hope and recovery for people with psychiatric disabilities; evidence-based treatment based on accurate, complete and timely assessments; and collaboration with our patients to identify the individualized skills necessary to live effectively and successfully in the community. LTCS strives to provide services that are responsive to the needs of its patients, cost-effective, consistent with the needs of public safety, and have positive outcomes. The core values of Long Term Care Services include the following.

- Leadership: The Long Term Care Services Division is committed to achieving and maintaining the role as a recognized state and national leader on issues affecting mental illness.

- Innovation: It values fostering an environment where innovative clinical and administrative approaches to treating patients, protecting staff and patients, and collaborating with external customers is encouraged in order to develop state-of-the-art treatments.

- Excellence: It values the pursuit of clinical, forensic, and organizational excellence. Its Excellence Project seeks to capitalize on quality improvement through innovation, leadership, and advocacy in the mental health field.

- Safety and Security: It values a secure, safe, therapeutic and supportive environment for the benefit of patients, staff, and community.

- Recovery: It values the recovery philosophy of mental health care, which includes person-centered, strength-based, holistic, and recovery-focused assessment, planning and treatment.

- Timely: It values goal-directed services that are promptly provided in order to restore and sustain the patients' and families' integration into the community.

- Efficient: It values the use of human and physical resources in ways that minimize waste and optimize access to appropriate treatment.

- Hope: It values the belief that a patient has the ability to get better.

- Dignity and Respect: It values an environment in which services are provided with respect for the rights and dignity of all individuals.

- Spirit of Community: It values a strong spirit of community by emphasizing employee creativity, open communication, and teamwork among staff, patients and families, all within the spirit of collaboration and pride of ownership.

- Individual Responsibility: It values individual responsibility and accountability. Employees and patients are encouraged to identify problems, propose recommendations, and implement solutions.

- Partnerships: It values mutually beneficial collaborations with and between internal and external stakeholders.

- Valuing Diversity: It values and is committed to the patient-driven delivery of services that recognizes the importance of culture and cultural competence.

CURRENT PRACTICES REGARDING HOSPITALIZATION

Long Term Care Services (LTCS) maintains its commitment to excellence in the provision of services to the mentally ill. To that end we have instituted a number of changes based upon best practices. Quality assurance reviews continue to yield valuable results that are reflected in our approach to services.

Among the changes in progress or already enacted are the development and implementation of policies and procedures based on a recovery model of mental health care that provides effective treatment consistent with generally accepted evidence-based practices of care. These include a person-centered, strength-based, holistic, and recovery-focused assessment and treatment planning system that is based on assessed needs of the individual child or adolescent. Treatment teams review and revise, as appropriate, treatment plans and evidence-based interventions for each patient on a specified schedule based on assessed treatment outcomes.

LTCS continues to implement policies and procedures to eliminate the use of seclusion and physical restraints, and these interventions will be reserved only for emergency use for safety of self, peers, and staff. We are creating a general physical environment and therapeutic milieu for treatment that is consistent with our values. This includes developing and implementing plans for enhancing supports and services that will enable patients to be discharged as soon as their mental health and legal issues have been resolved so they can be in a less restrictive level of care. This is being achieved by training staff to provide effective, positive interventions in a kind, caring, and compassionate manner to all in their care. Each discipline has specific targets to ensure better care. Psychiatrists need to assess, diagnose and prescribe medication based on a rational pharmacologic approach integrating information and feedback about psych-social and educational issues. Pharmacists are expected to play a more visible role in medication issues. Psychologists are expected to assess the need for and provide behavior therapy based on a positive behavior supports model and cognitive behavior therapy for the emotional and behavioral disorders experienced by the patients in their care.

All of our standards and operational processes are being reviewed and amended to ensure that patients at the state hospitals receive the most beneficial treatment possible in a setting that is committed and conducive to patients achieving the highest possible level of functioning in the shortest possible time.

ACTIONS TO IMPROVE PROGRAM PERFORMANCE

The Long Term Care Services embraces the concept of continuous quality improvement. Below are program performance improvement actions currently being implemented:

- Wellness And Recovery Model Support System (WARMSS). The WARMSS is a comprehensive computer software program that records: each patient's assessed needs as derived during initial treatment team planning sessions; patient-generated life goals; goals for each treatment session or class; available types and providers of treatment; a schedule and rosters of patients assigned to treatment sessions; degree of patient achievement of each treatment goal; changes in goals; and measures of progress in treatment. When WARMSS is deployed system-wide, DMH will be able to monitor and summarize data concerning amounts and types of treatments provided and the effectiveness of these treatments. The system is consistent with the wellness and recovery models of mental health that place special emphasis on client-driven treatment goals and services and in which services are often provided in treatment malls with a campus atmosphere and flexibility in tailoring available treatment to individual needs.

- Seclusion and Restraint. As part of DMH's commitment to provide treatment services that respect patient dignity and are the least restrictive possible, State Hospital staff continually strive to employ effective alternatives to minimize the use of emergency interventions such as seclusion and restraint. New strategies are being developed to restructure staff philosophy to 1) focus on recovery, patient choice, and safety rather than control; 2) improve early intervention practices, including staff training on de-escalation techniques; and 3) utilize special individualized behavior treatment plans for high-risk patients. It is anticipated that

changes to philosophy and practice to effect a substantial reduction in seclusion and restraint will take several years.

As of this date, the State Hospitals have implemented a new debriefing procedure to ensure we learn from patient choices or treatment methods that are ineffective and develop other plans that will avoid a future emergency; a new initial assessment process and a new data collection system to allow for posting State Hospital seclusion and restraint data on the Internet.

- Special Incident Reporting. California State Hospitals have made significant progress in reducing the number of reportable special incidents (events that have an adverse affect on the safety, care, treatment and rehabilitation of patients). The DMH has established a new data reporting system that allows statistical analysis of serious incidents. The data is reported separately from the narrative reports state hospitals use to report special incidents at the time of the incident. State hospitals now report data quarterly concerning all special incidents using uniform reporting methods, data sets, and definitions. Emphasis is placed on identifying common factors and trends so that preventative measures can be established.

- On May 2, 2006, the United States Department of Justice (USDOJ) and the State of California reached a settlement concerning civil rights violations at four California State Hospitals: Metropolitan State Hospital in Los Angeles; Napa State Hospital in Napa, Patton State Hospital in San Bernardino; and Atascadero State Hospital in San Luis Obispo. These hospitals provide inpatient psychiatric care to nearly five thousand individuals committed to the hospitals civilly or in connection with criminal proceedings. The extensive reforms required by the five-year Consent Judgment will ensure that individuals in the hospitals are adequately protected from harm and provided adequate services to support their recovery and mental health.

  The USDOJ conducted its investigation pursuant to the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA). This statute allows the federal government to identify and root out systemic abuses such as those identified in this case, rather than focus on individual civil rights violations.

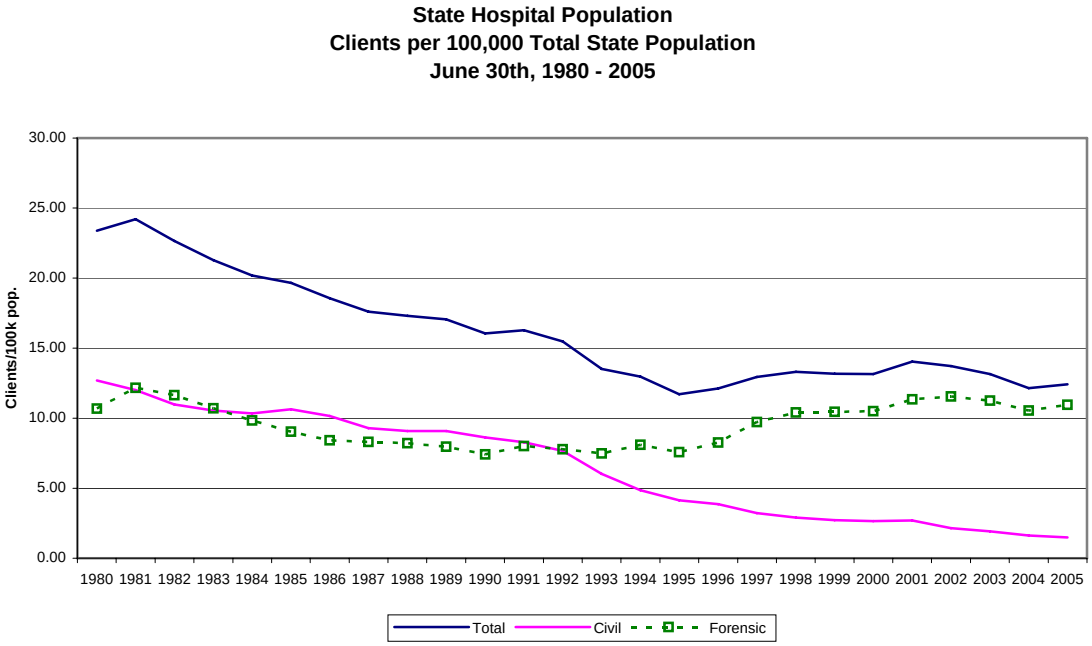
  The USDOJ investigations revealed civil rights violations, and found a pattern and practice of preventable suicides and serious, life-threatening assaults on patients by staff and other patients. Care provided at the hospitals was found to have departed from generally accepted professional standards, and individuals were not being served in the most integrated settings appropriate to their needs and the requirements of any court-ordered confinement. The State will now address and correct the agreed upon violations identified by the USDOJ.

  Chapter 74, Statutes of 2006, Section 74, requires the Department of Mental Health (DMH) to report quarterly to the Legislature on the status of compliance with the USDOJ's Consent Judgment. The reports are to include all monitoring reports produced in the previous six months by the court monitor and copies of other correspondence between the USDOJ, the count-appointed monitor, and DMH regarding compliance with the Consent Judgment. The Legislature has requested reports from DMH on a quarterly basis to contain all reports

received from the monitor and related correspondence. A copy of the Consent Judgment, which includes all of the required accountability and monitoring provisions, may be found at www.dmh.ca.gov/docs/ConsentJudgmentAgreement.pdf.

RATES OF HOSPITALIZATION

The State Hospital population peaked in 1956 with over 37,000 people in the State Hospitals at that time. The population steadily decreased for the next four decades until about 1996 when it began to increase slightly. The following graph shows the number of state hospital clients per 100,000 total State population from 1980 through June 2006. The lowest point was in 1995 when the State Hospital population on June 30 of that year was 3,788, or a rate of 11.71 people per 100,000 population. The graph also shows that the population who is voluntary or civilly committed continued to decrease while the forensic population has been increasing during the same period.



There are several reasons for these changes. First, in 1991 the State enacted the realignment legislation, which altered the fiscal and administrative responsibilities as well as the State and County relationship regarding the provision of mental health services. A significant component of realignment was the transfer of State funds used for state hospital services for civilly committed clients to the counties. Before realignment, the State allocated to each County a historically determined number of beds for voluntary and civil commitments. The Counties had little financial stake in, or programmatic control over, these beds. Realignment shifted the bed funding to counties along with the discretion over how to spend the funds to serve the needs of persons with serious mental illness. Counties could contract for state hospital beds or use the funds locally to hire staff

and/or contract for services. The results have been dramatic in terms of the impact on the state hospital population. Although the number of civil commitments was already decreasing, realignment hastened that decline from 8.28 people per 100,000 population in June 1991 to 1.49 individuals per 100,000 population in June 2006. This dynamic is shown in the above graph.

At the same time the civil committed patient population was decreasing, there has been an increase in the forensic population starting in 1995. This is due to an increase in the number of persons judged incompetent to stand trial, persons not guilty by reason of insanity, and mentally disordered offenders. In addition, California enacted a Sexually Violent Predator (SVP) law in 1995. This accentuated the increase in the forensic population with longer commitments. In order to manage the increasing forensic patient population, the DMH opened its fifth state hospital in September 2005, Coalinga State Hospital, which will house and provide treatment primarily for SVP individuals. It is likely that the forensic population will continue to increase. Current statistics show that 11.66 of every 100,000 Californians reside in a DMH state hospital under a penal commitment. Overall the combined rate of Californians institutionalized in DMH hospitals at the end of SFY 2005-06 was 13.15 per 100,000 population.

RESIDENTIAL ALTERNATIVES TO HOSPITALS

Several types of residential alternatives to State and local hospital services have been developed. Included are:

Community Residential Treatment Systems (CRTS)

CRTS are Social Rehabilitation Models that provide a wide range of alternatives to institutional care based on the principles of residential community-based treatment. Facilities are to resemble a normal home environment as much as possible. Medi-Cal reimbursement is available if the facilities have 16 beds or less, which provides an incentive for establishing smaller facilities. Three types of residential programs fall into the CRTS category: 1) short-term crisis residential, 30- day maximum; 2) transitional residential, 1 year; and 3) long-term residential, 18 months. Numerous services, including vocational and other ancillary services, are provided in these facilities. The DMH reviews, monitors, and certifies Social Rehabilitation Programs in CRTS. Certification by DMH, and licensure by the State Department of Social Services, are requirements for CRTS facilities.

89 CRTS FACILITIES 1,056 BEDS

Mental Health Rehabilitation Centers (MHRCs)

MHRCs comprise 24-hour mental health programs in facilities that are licensed by DMH. These facilities provide intensive support and rehabilitation services designed to assist persons, 18 years or older, with mental disorders who would have been placed in a State Hospital or another mental health facility. MHRCs are designed to help individuals develop the skills to become self-sufficient and capable of increasing levels of independent functioning within a psychosocial rehabilitation model.

Chapter 678, Statutes of 1994 (SB 2017), added Section 5675 to the WIC. This addition required the DMH to promulgate emergency regulations to establish the standards for a pilot project for Placer County and up to six other surrounding counties. The participant counties were to develop a shared 24-hour MHRC for the provision of alternative community care and treatment for persons who otherwise would be placed in a State Hospital or another mental health facility. This legislation also provided that DMH consider proposals for MHRCs from other counties.

Emergency regulations were adopted in August 1995. Permanent regulations were adopted in August 1997. In addition to the original Placer County MHRC pilot project, over the last decade many other MHRCs have been established under the provisions of the regulations. There are currently 23 DMH-licensed MHRCs statewide.

23 MHRC FACILITIES 1,670 BEDS

Special Treatment Programs (STPs) / Skilled Nursing Facilities (SNFs)

In 1974, California established STPs for those individuals in nursing homes who have mental illness, as part of its Medi-Cal services programs. STPs were developed to provide services to clients with chronic and persistent psychiatric illness who require 24-hour care and supervision. Clients who receive program services in STPs have moderate to severe mental illness, with a history of long-term illness that precludes them from being treated in an independent living setting or in other lower levels of care. These clients require ongoing supervision and may be expected to benefit from an active rehabilitation program designed to improve their adaptive functioning or prevent any further deterioration of their adaptive functioning. Currently, there are 30 SNFs (licensed by Department of Health Services) in California that have STPs certified by the DMH. The SNF/STP services in eight of the facilities are billed to the Medi-Cal program. The services in 22 of the facilities are covered by the counties through contracts with the facilities. The DMH is responsible for overseeing the programmatic aspects of the STPs in these 30 facilities, for developing appropriate statewide program policies and standards, and for providing technical assistance and consultation to the STPs/SNFs.

30 FACILITIES 2,607 BEDS

Psychiatric Health Facilities (PHFs)

PHFs, which provide non-medical acute inpatient psychiatric care, were established in 1978 as a low cost, high quality alternative to acute hospitalization. PHFs (in addition to MHRCs) comprise one of only two types of facilities actually licensed by DMH. As a prerequisite to licensure by DMH, PHFs are required to keep their costs or charges to approximately 60 percent of the costs or charges for similar services provided in a psychiatric or general acute care hospital. Those PHFs that are federally certified or accredited by a nationally recognized commission, and public facilities that are federally certified and serve a specified proportion of Medi-Cal patients, may apply to DMH to increase their per diem to 75 percent of the average costs or charges of a psychiatric or general acute care hospital.

The DMH currently licenses 18 PHFs, 8 of which are owned and operated by private organizations; local governments operate the remaining 10 PHFs.

18 PHF FACILITIES 405 BEDS

Community Treatment Facilities (CTFs)

CTFs are secure (locked) community residential treatment facilities providing mental health services to adolescents who are diagnosed as Severely Emotionally Disturbed (SED). The Department of Mental Health (DMH) is responsible for the development and distribution of 400 CTF beds within the five Mental Health Regions of California. DMH reviews, monitors, and certifies CTF programs, with the licensure handled by the Department of Social Services.

5 OPERATIONAL CTF PROGRAMS 140 BEDS

PREADMISSION SCREENING AND RESIDENT REVIEW

The Nursing Home Reform Act (NHRA), enacted as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA-87), revised federal laws governing nursing facilities (NFs). OBRA-87 requires that all individuals initially entering a NF must be screened to determine if they have a developmental disability or serious mental illness. On admission to a NF, a Preadmission Screening and Resident Review (PASRR) screening (Level I) is done for any resident expected to stay 30 days or more. The PASRR Level I screening is sent to the California Department of Health Services (DHS), as well as DMH and the California Department of Developmental Services (DDS), as appropriate, for an independent clinical field evaluation (PASRR Level II).

For residents identified as having, or suspected of having, a serious mental illness, a referral is made for the PASRR evaluation for Mental Illness (MI). PASRR/MI Level II screenings are conducted through an independent contract administered by DMH, which serves as the State Mental Health Authority (MHA). The contractor trains and sub-contracts with licensed clinical evaluators throughout the State to conduct these evaluations. The Level II is designed to evaluate the level of care needed, based on physical, psychosocial, and psychological needs; recommend specialized mental health services when necessary; and recommend other less-than-specialized mental health services from which the resident might benefit. Each field evaluation is reviewed, revised, and certified by the contractor's Medical and Quality Assurance Directors before it is transmitted to DMH.

DMH PASRR clinicians review the findings of the field evaluators and reach a decision, which becomes the official MHA determination. The individual evaluated is sent a letter explaining the MHA determination. Copies are mailed to the NF for distribution to the administrator, the resident's chart, the treating physician, the conservator (if one has been appointed by the court), and the local mental health plan. A Resident Request for Review form is attached to each letter, by which the resident, the facility or the conservator may ask questions about or disagree with the recommendations made for placement or services. The DMH also mails a copy of each

MHA determination letter to the DHS Medi-Cal Field Office to aid them in reviewing Treatment Authorization Requests for those individuals eligible for Medi-Cal reimbursement.

Each day, DMH clinical and administrative staff talk with DHS staff, contractor staff (i.e., Quality Assurance and Medical Directors, Contract and Office Managers), and NF staff about PASRR Level I screenings, Level II evaluations, and DMH PASRR determinations. On request, DMH PASRR clinicians consult with residents, NF staff members, conservators, family members (who have a Release of Information from the resident), and Medi-Cal Field Office or Licensing and Certification Office managers and staff. Consultation is often about implementing activities that address problematic behaviors, encourage therapeutic interactions with other residents and staff, and adapt NF activities to the resident's mental health needs.

During SFY 2004-05, DMH PASRR will be implementing a new, expanded consumer-interactive version of the PASRR/MI Level II evaluation. The new Level II will include a section on Community Placement Alternatives, for the consideration of the treating professionals. PASRR/MI evaluators will be trained about each alternative prior to conducting evaluations. In addition, the DMH PASRR determination letters will be expanded to reflect the additional community alternatives, for the consideration of the treating professionals.

SUPPORTIVE HOUSING

In SFY 1998-99, the DMH assumed a leadership role in the development of supportive housing for individuals with serious mental illness. In collaboration with county mental health departments, family members, and the nationally recognized Corporation for Supportive Housing (CSH), Stephen Mayberg, Ph.D., Director of DMH, initiated the Supportive Housing Task Force and 13 supportive housing demonstration projects were funded as a result of this collaboration. This commitment and momentum also fueled the passage of the innovative Supportive Housing Initiative Act (SHIA, AB 2780, Statutes of 1998, Chapter 310). The following is an update on these initiatives and other supportive housing activities within DMH.

The original 13 supportive housing demonstration projects completed their fifth year of operation in June 2004. Originally three year grants, the projects were given a two-year funding extension. These projects focused specifically on individuals with mental illness who are homeless, or at risk of homelessness, and they provided an important opportunity for participating counties to develop expertise in supportive housing.

With the implementation of the SHIA legislation in SFY 1999-2000, 11 supportive housing projects were funded, and over the next two years, an additional 35 projects received SHIA funding. The SHIA grants are used to develop affordable, service-rich housing for a number of populations with special challenges, including persons with mental illness, HIV/AIDS, substance abuse disorders, physical disabilities, developmental disabilities, CalWORKs (California's welfare-to-work program), elders, transition age youth, families with children, and persons who are homeless. The SHIA projects serve one or more of these populations.

The SHIA grant funds were allocated through a statewide competitive process and the total number of projects funded was 46. Of these 46 projects, the initial 11 completed their three-year funding cycle on June 30, 2003. Funding for the next 20 projects was completed on June 30,

2004. The remaining 15 projects were funded through June 30, 2005. Approximately $48.2 million in General Fund dollars were awarded for SHIA projects throughout California. These projects reflect a broad range of options for both housing and services, but they all provide permanent housing with supportive services offered onsite and in the community. The projects are located in both rural and urban communities, and it is estimated that 8,400 individuals will be served in these projects.

Over the past five years, DMH has put forth a consistent effort to expand the availability of permanent, affordable housing with a range of flexible, meaningful services for individuals with disabilities. This effort has involved significant collaboration and mutual education among agencies (both public and private), State Departments, County Departments, and many committed individuals along the way. In SFY 2004-05, there was no funding available for new SHIA projects; however, the sunset date for the SHIA legislation remains extended through January 1, 2009.

In addition, the Mental Health Services Act (MHSA) provides funding for services and supports that promote wellness, recovery and resiliency for adults and older adults with severe mental illness and for children and youth with serious emotional disorders and their family members. In order to receive MHSA Community Services and Supports funding, each county must develop a three-year program and expenditure plan. A portion of the MHSA funds can also be used for capital facilities and technological needs to support community-based integrated service experiences for clients and their family members, consistent with the county's Community Services and Supports Program and Expenditure Plan. Capital facilities can include housing and other buildings that enable mental health clients and their family members to live in the most independent, least restrictive housing possible in their local community and to receive services in community-based settings that support wellness, recovery and resiliency. Decisions about how to use the MHSA funds available for capital expenditures must be guided by the overarching transformation goal. The Department is fully vetted and actively involved in a public stakeholders process to solicit input on ideas for effective use of MHSA Capital Facilities funds. No decisions regarding implementation of plans for Capital Facilities funding will be made until all stakeholder input is considered.

Governor's Homeless Initiative—The Governor's Homeless Initiative (GHI) creates a housing finance model that ties together California Housing Finance Agency (CalHFA) debt financing, tax credits, capital subsidies (Proposition 46) and MHSA funds to encourage development of supportive housing projects that target chronically homeless individuals with serious mental illness. This Initiative offers a non-traditional centralized loan and application approval process. Approximately $3.15 million from MHSA funds in FY 2005-06 are targeted for this initiative, with $2 million designated for rental subsidies, $750,000 designated for pre-development costs, and $400,000 distributed to establish supportive housing development collaboration at the local level. The focus of the efforts at the local level has begun with the implementation of DMH sponsored Regional Housing Trainings being conducted throughout the State. The goal for these trainings is to bring together county mental health departments, county housing agencies, housing developers, and community-based service providers to share expertise and leverage resources to develop more housing opportunities for homeless people with serious mental illness. County mental health departments are a fundamental component of this collaborative effort, and they are required to provide a long-term commitment to fund supportive services for a project to qualify for approval under this collaborative initiative.

MHSA Housing Initiative—On May 12, 2006, Governor Schwarzenegger issued Executive Order S-07-06 to continue the interagency collaboration established through the Governor's Homeless Initiative by designating up to $75 million in existing Mental Health Services Act (MHSA) funding each year to develop and build housing for individuals with mental illness, and their families, who are chronically homeless. It is anticipated that these MHSA resources will be leveraged to secure an estimated $4.5 billion in other funding sources and would enable the construction of over 10,000 new housing units. As a condition of receiving funds, county mental health departments are required to provide the supportive services necessary to maintain these individuals in their homes. This blend of safe, affordable housing with accessible supportive services is essential for homeless individuals with serious mental illness to stabilize their health and live and work in our communities.

Other DMH activities focused on the development of supportive housing include housing assistance and options developed under the AB 2034 program (please refer to Adult Criterion 4 for a description of this program). DMH staff are also integral in the planning and coordination of the Annual Housing and Homelessness Conference for all county housing and homelessness coordinators. This three-day conference continues to grow each year, and it provides an opportunity to share information regarding best practices in the field of homeless services and supportive housing, as well as a discussion of both State and federal policy developments related to housing individuals with serious mental illness. DMH housing staff also continue to participate in the certification of supportive service plans for the HUD, Section 811 applications.

OLMSTEAD VS. L.C. DECISION

The Supreme Court ruling in the case of *Olmstead vs. L.C.,* issued in June 1999 stated that the unjustified institutionalization of people with disabilities is a form of discrimination under the Americans with Disabilities Act (ADA). According to the Court, when individuals with disabilities desire and are deemed appropriate for community placement by qualified professionals, and these individuals remain institutionalized, such unnecessary segregation violates the ADA.

The federal Center for Mental Health Services (CMHS) is committed to assisting states to expand resources and opportunities for people with serious mental illnesses to live in their home communities. This includes facilitating necessary partnerships among service delivery systems and stakeholders. CMHS has offered annual grants to State Mental Health Authorities to support efforts to build coalitions to promote community based care. CMHS is authorized to provide financial support to each of the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands in the amount of $20,000 per year, for a total of three years (subject to funding re-authorization), for the purpose of organizing and supporting the activities of State-level coalitions.

Within California, and under the leadership of DMH, the CMHS grant funds were initially used to contract with the California Institute for Mental Health (CIMH) for the services of a Project Coordinator to conduct regional conferences focused on educating consumers and mental health professionals about Olmstead and related issues such as supported employment. Three

conferences were planned and held in April of 2003. The Olmstead Project Coordinator and DMH staff also assisted the California Health and Human Services Agency (CHHSA) Long Term Care Council (LTC) in the development of the California Olmstead Plan that was submitted to the California State Legislature in May of 2003. This effort included facilitation of stakeholder meetings across the State as a way to gather information and develop priorities for the Olmstead Plan.

In March 2004, DMH was awarded a second round of three-year funding from CMHS to continue Olmstead implementation activities under the New Freedom Initiative: State Coalitions for Community Based Care. This funding focuses on developing and conducting a staff training that will facilitate successful transitions of people from Institutions for Mental Disease (IMD) into the community. This pilot training, based on recovery–oriented, culturally-competent treatment and discharge planning, will be offered to IMD administrators and staff, as well as county personal service coordinators. The Los Angeles County Department of Mental Health has been chosen to be the initial participating county for the development of this training.

The original goal of the grant was to develop a recovery-oriented, culturally competent assessment, treatment and discharge planning curriculum and learning process for staff of Institutes of Mental Disease (IMDs) and county mental health liaisons to these facilities, that will facilitate successful transitions of people from these institutions into the community and to train and mentor three IMDs/Counties using this curriculum and learning process. The general concept for the IMD planned training consisted of two aspects: a structured curriculum that can be individualized to a specific IMD and county, and a follow-up mentoring process that will be designed to meet the particular needs of the IMD and the partnering county. The SAMSHA Illness Management and Recovery Toolkit was selected to use in the IMD along with training about systems issues affecting IMD use based on the two-year study completed in 2005.

From the beginning the focus has been on systems, not just the IMD. This focus is justified by the findings of CIMH'S statewide study "Long Term Strategies for Community Placement: Alternatives to Institutions for Mental Disease."

An all day training occurred on October 18th with key Los Angeles mental health system components represented including: the selected IMD which is Community Care Center (CCC) in Duarte, AB2034 and ACT team leadership, IMD administration, the public guardian, parents, consumers, and staff from The Village and Project Return.

A kick-off meeting was held with all CCC staff for training within the IMD on the Illness Management and Recovery (IMR) Tool Kit on December 5th.

CCC began the training in January, with implementation scheduled to start in April. The contractor will be having regular contacts with the facility about their progress and will conduct a fidelity site visit prior to the end of June. Implementation of the IMR program within CCC will just be beginning when the grant ends June 2006.

Additional benefits from the Olmstead Grant to date:

- AB2034/ACT team leadership in LA has requested a similar training based on the IMR and the training day CIMH did in April. It is highly desirable to use this same model to create integrated service experiences for clients, an essential goal of the MHSA and DMH. They are paying for this training.
- LA IMD Administration is planning to take the following steps:
    - To train all IMD's in this model. Their intention is to have a similar one-day training as the one CIMH did in April.
    - To identify at least two consumer trainers to work with CIMH
    - To identify two staff from IMD administration to become trainers so that they will work with other IMD's on an ongoing basis. (CCC will be the model)
    - LA IMD Administration will fund this training

SERVICES TO OLDER ADULTS

The 2000 Census showed that, in California, just over 14 percent of the population are aged 60 or older. In general, California's older adult population, age 60 and over, is not only growing but is getting older and is expected to reach its peak some time around 2030 as the oldest of the baby boomers reach 85, while the youngest reach 65. California already has a proportionately larger share of people in their 40s than other states, and those people will be at or near retirement age within the next 20 years. Almost 20 percent of those who are 55 years and older experience specific mental disorders that are not part of "normal" aging. The most common mental health disorders treated are schizophrenia; mood disorders, including depression and bipolar disease; anxiety disorders and adjustment disorders. Within California, older adults account for about 2 percent of dollars spent for all mental health services.

Older Adult System of Care (OASOC) Demonstration Projects

Major barriers currently hinder the delivery of adequate mental health services to older adults, and these barriers will only become more pronounced as the number of older people dramatically increases. System barriers to care include: shortages of health and social service personnel who have expertise in providing geriatric mental health care, multiple health insurance plans, disparate and unreliable funding streams, multiple entry points, multiple third-party payers, and an incomplete patchwork of state and local laws and policies. Individual barriers include: language and culture, the stigma associated with mental illness and subsequent denial of the need for services and geographic and social isolation.

The California Mental Health Master Plan: A Vision for California (March 2003) has long recognized older adults as a distinct population in policy and planning decisions. It is clear that older adults need and benefit from distinct and specialized programs within the mental health system. In July 2001, four counties received federal SAMHSA Block Grant funds to begin serving older adults through OASOC demonstration projects. The four counties comprising the demonstration project were Humboldt, San Francisco, Stanislaus, and Tuolumne.

The goal of the three-year OASOC project, which ended June 30, 2004, was to develop strategies, protocols and methodologies that reduce barriers to care thereby establishing or re-establishing the quality of life for older adults in partnership with their families and community support systems. Methodologies of the OASOC project included intensive and creative outreach, recovery supported by timely access to high quality clinical services, culturally-based practices that were identified and selected with client and family involvement, and services that focused on the strengths of the client so that a sense of identity, dignity, and self-esteem were retained. Demonstration project staff collected data and developed guidelines for assessment and treatment protocols. Those protocols were age and gender-appropriate assuring that services met the special needs of older adults dealing with poverty, isolation, failing health and substance abuse and/or who were at risk of institutionalization.

The findings and results of the demonstration projects were compiled into a report that has been disseminated through the DMH web site and to county mental health departments through the California Mental Health Directors Association (CMHDA). According to the report, the demonstration projects:

- Successfully established coalitions and achieved coordination between relevant agencies and other entities on behalf of older adults in their communities.

- Successfully implemented the practical aspects of their older adult system of care designs to increase older adult access to services, including mobile units, staff in primary care settings, peer counseling development, combined assessment of mental health and medical issues, outreach, and primary care education.

- Increased the number of older adult persons they assessed/served through system of care services. (All of the projects exceeded the target number of older adult consumers specified in their grant proposals.)

- Resulted in improved quality of life and functional outcomes, as well as very positive perception of service quality and high services satisfaction, as reported by older adult consumers.

- Successfully demonstrated accountability due to the focus on evaluation, project monitoring and outcomes.

Two years ago, CMHDA established an Older Adult System of Care Committee that provides a structural link between DMH efforts and local efforts in establishing effective OASOC for older adults. The DMH actively participates in the meetings of this committee and collaborates in policy formulation, the expansion of older adult programs, and the development of training, conferences, and services associated with older adult services. Additionally, as a result of feedback from statewide older adult services and from the demonstration projects, a transitional age subcommittee of the older adult committee was formed. The mission of this subcommittee is to explore the needs of individuals in the 55-59 year old age group who would benefit from the array of services typically offered in an OASOC but who do not meet the OASOC age requirement. Examples of situations where additional services are needed for this age group are

when they are transitioning to the community or other phase of life, when they have complex medical or chronic health issues that have a mental health component, or when transitioning to the older adult system of care.

MHSA

Older Adults are a focus of the MHSA. The W&I Code, Section 5813.5 specifies that MHSA services will be available to adults and seniors with severe mental illnesses who meet the eligibility criteria in the W&I Code Section 5600.3(b)—adults and older adults who have serious mental disorder and (c)—adults and older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.

Older adults 60 years and older with serious mental illness including older adults with co-occurring substance abuse disorders and/or other health conditions who are not currently being served and have a reduction in personal or community functioning, are homeless, and/or at risk of homelessness, institutionalization, nursing home care, hospitalization and emergency room services. Older adults who are so underserved that they are at risk of any of the above are also included. Transition age older adults (as described above) may be included under the older adult population when appropriate.

PROGRAMS FOR ADULTS WITH COGNITIVE IMPAIRMENT AND THEIR FAMILIES

California families are over two times more likely to encounter cognitive brain-impairing conditions than other mental disorders, according to current incidence data. Landmark legislation responded to this need by creating two programs, the Statewide Caregiver Resource Centers Program and Traumatic Brain Injury Services of California.

Statewide Caregiver Resource Centers

Under the Comprehensive Act for Families and Caregivers of Brain-Impaired Adults (Welfare and Institutions Code Section 4362 et.seq.), the DMH established the Caregiver Resource Center (CRC) System in 1984. This is a statewide program consisting of 11 non-profit centers serving all 58 counties in California. The Caregiver Resource Centers (CRCs) provide a range of support services for families and caregivers caring for adults with debilitating cognitive impairments including Alzheimer's; multi-infarct disease or other dementias; cerebro-vascular diseases such as stroke or aneurysm; degenerative disease which causes both physical and cognitive impairment such as Parkinson's, Huntington's, multiple sclerosis and amyotrophic lateral sclerosis; brain injury due to trauma or infection; brain tumor; and HIV-related dementia.

Services are designed to deter institutionalization, allow caregivers to maintain a normal routine, and promote quality care. The range of services for family caregivers includes specialized information and referral, in- home assessment of caregiver needs, family consultation and care planning, respite care, support groups, legal/financial consultation, caregiver education and training, counseling, home modifications, emergency response, and advocacy.

Additionally, the law established a Statewide Resources Consultant (SRC) to 1) operate a statewide information clearinghouse on caregiving and brain disorders; 2) conduct education, training and applied research; 3) implement program and policy development; 4) maintain a statewide database on CRC clients served; and 5) provide technical assistance to CRC sites.

In SFY 2003-04, the total contract award to the 11 CRC sites and the SRC was $11.7 million. This program is 100 percent funded by State General Funds. On the average, the CRCs generally serve more than 14,000 families and caregivers of persons with adult-onset brain disorders each year.

Traumatic Brain Injury Services of California

This program for adults with Traumatic Brain Injury (TBI) was initiated with the passage of Senate Bill 2232 (Chapter 1292, Statutes of 1988), which was later amended by Assembly Bill 1492 (Chapter 1023, Statutes of 1999). This legislation establishing the TBI services is set forth in Welfare and Institutions Code Section 4354 et. seq. The purpose of the project is to demonstrate the effectiveness of a coordinated service approach to assist persons with TBI to attain productive, independent lives.

The DMH currently contracts with community organizations to develop and operate seven project sites statewide. These seven sites demonstrate diverse approaches to service delivery and coordination. Two are hospital-based—Mercy General Hospital in Roseville and St. Jude Medical Center in Fullerton. The other five are community-based. They include The Betty Clooney Foundation in Long Beach, the Central Coast Center for Independent Living in Capitola, The Janet Pomeroy Center, in San Francisco, Making Headway in Eureka and Central Coast Neurobehavioral Center in Morro Bay.

The target population for this project is persons 18 years of age or older with an injury that was sustained after birth from an external force to the brain, or any of its parts, resulting in psychological, neurological, or anatomical changes in brain functions. Funding for the project comes from the TBI Fund. Sources of deposits into the Fund come from the State Penalty Fund that is supported by the fines paid by motorists for various violations of California's Vehicle Code. At least 51 percent of clients served by the project must be Medi-Cal eligible or have no identified third party funding source.

Services are provided directly or by arrangement and include case coordination, community reintegration services, vocational services, and supported living services. Functional assessments of clients are used to identify level of functioning in such areas as activities of daily living, mobility, communication skills, psychosocial adjustment, and cognitive functioning.

CO-OCCURRING SUBSTANCE ABUSE AND MENTAL DISORDERS (DUAL DIAGNOSIS)

The increasing awareness and acknowledgement of persons exhibiting co-occurring substance abuse and mental disorders, or dual diagnosis, is an issue of national concern. It is estimated that approximately 60 percent of persons with a serious mental illness also have a substance abuse

problem, and that up to 90 percent or more of the highest cost users of mental health services, including forensics consumers, also abuse substances.

The Department of Alcohol and Drug Programs (ADP) and DMH have long recognized the critical need of working cooperatively to provide quality treatment services to individuals with co-occurring disorders. Building on the efforts that have taken place since 1995, DMH and ADP, in collaboration with the County Alcohol and Drug Program Administrators Association of California, the California Mental Health Directors Association, the Alcohol and Drug Program Institute, and the California Institute for Mental Health, convened the Co-Occurring Joint Action Council, which meets quarterly.

The Council's joint vision statement — "One Team with One Plan for One Person" — states that "Each individual receives a comprehensive assessment that results in the formation of an interdisciplinary and possibly interagency team that will develop one individualized treatment plan for that person within a reasonable period of time. This plan will specify all necessary services and supports to be delivered by the single interdisciplinary service team that has all the needed skill sets and the right members in place from each agency. The individual client will have a strong voice in shaping the plan in development and implementation. The plan is expected to evolve as needed as that person progresses."

Additional efforts by the DMH in the area of co-occurring disorders include the following:

- The DMH has permanently setting aside $8,059,000 of its annual SAMHSA Block Grant for allocation to counties to support existing efforts in providing integrated treatment services for adults with co-occurring disorders. Counties are required to submit to DMH expenditure plans describing their intended use of the additional funds for the DMH's review and approval.

- The DMH received one of SAMHSA's Evidence-Based Practices grants, now in its third year of implementation, to 1) provide training and technical assistance to implement the Integrated Dual Diagnosis Treatment (IDDT) model in eight sites throughout California; 2) evaluate the implementation process and fidelity to the IDDT model; and 3) develop the infrastructure to foster statewide implementation of evidence-based practices.

- The DMH and ADP received a Second National Policy Academy grant for addressing co-occurring disorders from SAMHSA on October 12, 2004. The purpose of National Policy Academy grants is to assist States in building the necessary infrastructure and policy development for addressing co-occurring disorders. California recently submitted to SAMHSA its Action Plan for improving access to prevention, specialty treatment, and other services for persons with co-occurring disorders. To better address State-level policy and program issues on co-occurring disorders, DMH and ADP merged the National Policy Academy into the Co-Occurring Joint Action Council.

  In the spring of 2005, a workgroup tasked to implement the Substance Abuse and Mental Health Service Administration (SAMHSA) COD state action plan began meeting. Members of the SAMHSA COD National Policy Academy and the joint association representatives

coalesced into the forum called the Co-Occurring Joint Action Council (COJAC). The COJAC will be adding representation to broaden input and to facilitate moving the action plan forward with the deepest and broadest input possible.

ELIMINATING MENTAL HEALTH DISPARITIES TO RACIAL ETHNIC POPULATIONS/ CULTURAL COMPETENCE

California is one of the most demographically diverse states in the nation. California's population has grown by over 21 percent since 1990. The following tables show the diversity of the State population. California is now a multicultural majority state. Multicultural populations now comprise more than 51% of the State population. The State's Hispanic/Latino population has grown by 50 percent, from 7.7 million in 1990 to nearly 11.7 million in 2003, followed by the Asian/Pacific Islander population, up over 61 percent from 2.7 million to 4.4 million in the same time period. The Hispanic category includes all persons who indicated Hispanic or Latino in the 2000 Census. The remaining categories include only those persons who did not identify themselves as Hispanic or Latino. In the 2000 census, California's combined ethnic and racial populations became the majority; this trend continues in 2005. These changes make it imperative that mental health policies, services planning are designed with this growing diversity in mind.

The following table shows the distribution of the unduplicated clients served in State Fiscal Year 2003-04. The client population reflects the diversity of the State population although not all groups are represented proportionally to the State population.

TOTAL POPULATION
BY RACE AND AGE GROUP
July 1, 2005

RACE/ETHNICITY	Total	AGE GROUP		
		0-17	18-64	65+
Total	37,372,444	10,509,172	22,819,942	4,043,330
White	17,731,217	3,647,457	11,358,694	2,725,066
Hispanic	12,300,819	4,798,582	6,855,127	647,110
Asian/pacific Islander	4,684,467	1,302,059	2,940,608	441,800
Black	2,433,988	709,080	1,520,429	204,479
American Indian	221,953	51,994	145,084	24,875

UNDUPLICATED CLIENTS BY RACE / ETHNICITY AND AGE GROUP
FISCAL YEAR 2003-2004

Race / Ethnicity	Total	Age Groups					
		0 - 8	9 - 17	18 - 59	60 - 64	65 +	Age Unknown
Total	628,928	84,027	141,876	376,600	11,189	13,303	1,933
White	259,522	25,427	47,220	173,674	5,205	7,442	554
Hispanic	154,638	29,924	46,270	74,003	1,688	2,062	691
Black	110,886	15,641	25,941	66,569	1,182	1,275	278
American Native	5,220	704	1,199	3,195	53	58	11
Vietnamese	6,050	272	627	4,538	396	208	9
Chinese	5,540	583	771	3,516	246	413	11
Filipino	4,966	310	747	3,571	126	197	15
Cambodian	3,244	123	522	2,415	129	52	3
Laotian	2,842	108	344	2,228	104	53	5
Korean	2,114	149	282	1,503	89	89	2
Japanese	1,093	37	128	800	40	87	1
Asian Indian	621	58	99	428	17	16	3
Amerasian	454	54	102	281	10	6	1
Other Asian or Pacific Islander	7,816	335	913	5,942	440	175	11
Samoan	316	56	110	144	2	1	3
Hawaiian Native	191	29	45	113	2	2	-
Guamanian	172	29	39	100	3	-	1
Multiple Races or Ethnicities	16,748	4,201	5,113	7,105	158	99	72
Other	8,506	707	1,335	5,677	449	299	39
Unknown / Not Reported	37,989	5,280	10,069	20,798	850	769	223

The DMH is currently developing the most effective, efficient mental health service system that will meet the diverse cultural and linguistic needs of the State's population. Both access to, and effectiveness of, care are affected by the level of culturally competent mental health care that State and local providers are able to deliver. Providing culturally competent care is viewed as an overall quality of care issue. California has taken a developmental approach to moving culturally competent services forward. The DMH has assumed a leadership role by establishing the Office of Multicultural Services (OMS) at the Director's Office level.

For the past seven years, the DMH OMS has had in place an active Cultural Competency Advisory Committee (CCAC) to provide assistance and advice in developing culturally competent mental health services. The CCAC is chaired by the Chief of the Office of Multicultural Services and is

composed of representatives from the CMHDA, consumers and family members of both adults and minor children, community organizations and their representatives, County Ethnic Services Coordinators, and the academic community. The membership of the CCAC is ethnically and racially diverse. Since the release of the 2001 U.S. Surgeon General's *Supplemental Report on Mental Health: Culture, Race, and Ethnicity*, and the 2003 DHHS report, *The President's New Freedom Commission on Mental Health Achieving the Promise: Transforming Mental Health Care in America*, the DMH OMS with the CCAC has been working to incorporate information and recommendations into state and local level cultural competence planning. Other ongoing activities of the CCAC and the Office of Multicultural Services include:

- Addressing ongoing multiple strategies to eliminate disparities in access to and quality of care for the State's multicultural populations, including a specific focus this year on Latino population access to care issues;

- Embedding cultural competency into program policy plans at the State and local levels, including the CMHPC's Master Plan, Evidence-Based Practice strategies, trainings, Quality of Care redesign efforts, and a major focus of cultural competence and reducing ethnic/racial disparities within the Mental Health Services Act;

- Providing training and support to consumer and family members organizations for inclusion of more multicultural voice in their planning and embedding of cultural competency in their planning;

- Planning for more specific training in the area of cultural competency; and

- Implementing a process begun in 2003 for revising the DMH Cultural Competence Plan Requirements; this is the third revision of the CCPR since first issued in 1997.

The DMH is aware of and concerned with the current mental health disparities that exist in our state for multi cultural communities. The Mental Health Services Act (MHSA), which California voters approved in November of 2004, provides an opportunity to transform the mental health system in California. Through the MHSA, DMH is addressing Goal 3 of the President's New Freedom Commission on Mental Health Report "to eliminate disparities to racial ethnic communities in mental health." In addition, DMH's Vision Statement and Guiding Principles for MHSA implementation states that "as a designated partner of this critical and historic undertaking, the DMH will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system."

To this end, the MHSA-Community Services and Supports Three-Year Program and Expenditure Plan Requirements, when finalized, will address the elimination of mental health disparities, and include the following components:

- In selecting the initial population, counties must give specific attention to reducing racial/ethnic disparities.
- There are specific requirements to address unserved and underserved populations that have been adversely affected by lack of access to mental health services.

- There are several requirements counties must address regarding historically unserved populations.
- There is a technical assistance document entitled *Embedding Cultural Competence in MHSA*, as a resource for counties in planning and implementation efforts.
- There are requirements for counties to provide an analysis of the organization and service provider strengths and limitations in terms of capacity to meet the needs of racially and ethnic diverse populations in the county. This analysis must address the bilingual staff proficiency for threshold languages.
- There are specific requirements for counties to compare and include an assessment of the percentages of culturally, ethnically and linguistically diverse direct service providers as compared to the same characteristics of the total population who may need services in the county, and the total population currently served in the county.
- There are specific requirements for counties to provide an analysis and include a discussion of the possible barriers their system will encounter in implementing the programs for which funding is requested and how counties will address and overcome these barriers and challenges. Challenges may include such things as difficulty in hiring staff due to human resource shortages, lack of ethnically-diverse staff, lack of staff in rural areas and/or on American Indian reservations and rancherias, difficulties in hiring clients and family members, need for training of staff in recovery/wellness/resiliency and cultural competence principles and approaches, and need to increase collaborative efforts with other agencies and organizations.
- Current work on the performance outcomes in both the individual and system level performance outcomes will include attention to data collection to inform future planning to eliminate mental health disparities.

In addition to the above activities, the DMH provided funds to local mental health agencies for training on cultural and language competency. The OMS is currently working with CIMH's CMD on a grant from The California Endowment to assess effectiveness of cultural competence efforts at the local level, and identify training and technical assistance needs and development of county cultural competence profiles. The DMH, local CMHDA Ethnic Service Managers/Coordinators (ESM), and the CCAC have been working collaboratively with the CIMH CMD to address ongoing statewide planning for moving forward cultural competency efforts. A statewide meeting was held with key stakeholders in October 2004 with the CMHDA, ESM, CIMH CMD and DMH OMS to address ongoing strategic planning for eliminating racial ethnic disparities in mental health.

The DMH has also designated the Chief of OMS to serve as the State liaison and consultant to county Ethnic Service Managers/Coordinators; the State Quality Improvement Council; the State Compliance Advisory Committee; the California Health and Human Services Agency, Committee to Eliminate Racial, Ethnic Health Disparities; the Women's Mental Health Policy Council; the Statewide Planning Committee for Cultural Competence and Mental Health Summits; and the CIMH CMD.

PATIENTS' RIGHTS ADVOCACY PROGRAM

In 1991, California law was amended to bring it into conformance with the Protection and Advocacy for Individuals with Mental Illness (PAMI) Act. Californians with mental illness, and who are receiving voluntary or involuntary treatment in mental health facilities, are guaranteed numerous rights under State and federal law, including the right to be free from abuse and neglect, the right to privacy and dignity, and the right to basic procedural protections in the commitment process.

Current statute, Chapter 546, Statutes of 1995 (SB 361), requires DMH to contract out the patients' rights advocacy services with a single nonprofit agency on a multiple-year basis for a term of up to three years. Effective January 1, 2005, DMH renewed a three-year contract with Protection and Advocacy, Inc. (PAI) to provide mental health advocacy services through the Office of Patients' Rights (OPR). The OPR staff provides direct advocacy and investigative services in each of the State Hospitals, and training and technical assistance for all patients' rights advocates in the counties. The OPR is also responsible for responding to second level complaint appeals that could not be resolved at either the county or State Hospital level.

MEDICAL AND DENTAL SERVICES

The majority of adult clients served by the public mental health system (approximately 60 percent) are eligible for California's Medi-Cal (Medicaid) program, which provides essential medical care and services to preserve health, alleviate sickness, and mitigate handicapping conditions for individuals or families on public assistance, or whose income is not sufficient to meet their medical needs. The covered services are generally recognized as standard medical services required in the treatment or prevention of diseases, disability, infirmity or impairment. California's program is quite comprehensive and provides services in all major disciplines of health care.

The current Denti-Cal program, which is part of the Medi-Cal program, provides an array of dental services that includes, but is not limited to, diagnostic and preventive dental hygiene, such as examinations, x-rays, and teeth cleanings; emergency room services for pain control; tooth extractions; root canal treatments; prosthetic appliances; and orthodontics for children who qualify. The current dental fiscal intermediary, Delta Dental of California, operates a Beneficiary Services Unit that provides, among other services, dental referrals for beneficiaries and a beneficiary outreach component that focuses on underserved counties in California.

EDUCATION ACTIVITIES FOR ADULTS

Supported education activities are an integral part of recovery principles and are reflected in the training and technical assistance opportunities available through the DMH/Department of Rehabilitation (DOR) Cooperative Program. Through this program, community college consultants provide training and/or technical assistance on building collaborations with local educational programs to establish best practices in using mainstream educational resources as part of client's employment goals.

In addition, within California's adult integrated service programs for persons who are homeless or at risk of homelessness (AB 2034), the provision of comprehensive services is not limited solely to mental health services. Also included are supported employment and/or education, wherein clients are encouraged to identify personal goals in employment and/or education that might not be easily achieved without service supports. The supports provided vary from individual to individual based on their specific needs, but might include anything from helping a client identify classes that would be appropriate to working with an educational institution about necessary accommodations. Within California's adult integrated service programs, outcomes associated with educational activities are being tracked and reported, and are contained within DMH's annual report to the Legislature.

REHABILITATION AND EMPLOYMENT SERVICES

The importance of rehabilitation and employment services, within an effective consumer-directed system of care, is supported by the values and principles of the recovery and psychosocial rehabilitation models. The DMH has maintained and strengthened its role in providing employment services for persons with severe psychiatric disabilities by recognizing and building upon the interdependence of key State and local agencies. The DMH has taken a leadership role in creating employment strategies, services, and systems development at both the State and county level through its collaborative partnership with the DOR.

The State-level Interagency Agreement between DMH and DOR provides the administrative support, training, and technical assistance for the 25 local cooperative programs to develop, expand, and/or improve their interagency employment services. Local mental health/rehabilitation cooperative programs provide the employment and rehabilitative support services for persons with severe psychiatric disabilities. They represent best practices for transitioning and supporting consumers throughout their employment and have been developed with consumer and family member participation. These programs closely adhere to the values of comprehensive service linkages, consumer career choice, placement in a competitive and integrated environment, and proactive ongoing support. In SFY 2004-05 8,496 persons with severe psychiatric disabilities were provided services in these 25 programs, with 947 persons meeting DOR's defined outcome of becoming successfully employed. 3,205 new referrals for service were received during this time period.

Training and technical assistance are the key tools used to develop the local employment programs that support the consumer's choice to work. Training is customized to meet the individualized needs of the local programs and their communities. Training sessions can be delivered by topic or can be developed in a focused training series that addresses the skill development needs of the local partners. Subject matter specialists are contracted through DMH to provide statewide training and technical assistance. The subject areas address the values and principles of the recovery model as the basis for building programs and systems for employment services. All trainings are provided at no cost to the local partnership communities.

The subject areas for training and technical assistance for FY 2006-09 are: Building System/Community Capacity for Employment; From Vision to Transformation-Management Level Training and Organizational Building; Shifting to the Recovery Culture: Program/Line Staff Level Trainings and Cooperative Team Building; How to Engage the Employment/Business Community; Utilization of Mainstream Educational Resources in the

Design of Your Program; Benefits Planning; Connecting Employment with Recovery; The Client's Perspective—Supporting Education and Employment Goals; System/Program Assessment, Planning and Development; Transition Age Youth; Job Retention for Clients in Employment; Developing and Implementing Technical Assistance and Customized Training. These trainings are funded through the Interagency Agreement between DMH and DOR and are available statewide at no cost to the local programs.

In addition to individual training opportunities, the Employment Partnership Training Series is an 8-day curriculum that is delivered to local communities in 1 or 2 day increments over a 4-8 month period. It targets all persons/agencies interested in local community development of services, resources and supports to assist individuals with disabilities. The Series topics are can be individualized to meet the needs of the programs.

California's Building Employment Services Teams (BEST) Networks have been developed statewide to broaden access to local technical expertise and resources, to build community partnerships, and to provide advisory body input. They function as community focus groups to support and maximize employment services and opportunities in their communities. Key stakeholders represent their communities' needs and include members such as consumers, employers, family members, representatives of mental health, rehabilitation, community colleges, Social Security, Independent Living Centers, the Employment Development Department, the DMH, housing and transportation authorities, and service provider staff. BEST Technicians are contracted through DMH to provide administrative support for the local BEST Networks. The Technicians have current or past consumer experience with public mental health and are clients of DOR. This Transitional work experience assists them in their individualized career development. Additionally, a Outcome Tracking Program has been developed to gather comprehensive information from the statewide Cooperative Employments program participants after they have begun working. Long term employment outcomes and satisfaction data is collected by local Outcome Tracking Technicians through a series of personal interviews with consumers. As former recipients of services these Outcome Technicians add a highly effective peer-to-peer expertise to the interview process. This program has developed systematic long-term tracking of job retention, benefits, and career status, health and life changes, and other outcomes needed to improve evaluation, accountability and program development.

In addition to the above programs and services, the AB 2034 program provides employment services for persons who have a mental illness and are homeless, or at risk of homelessness. Employment has been identified as a primary focus for SFY 20007.

LIMITED EXAMINATION AND APPOINTMENT PROGRAM (LEAP)

The Limited Examination and Appointment Program (LEAP) provides an alternative to the traditional methods of the civil service examination and appointment process to facilitate the hiring of persons with disabilities.

The DMH currently provides funding to the State Personnel Board in support of the LEAP process and refers LEAP employment lists to hiring supervisors who recruit for job vacancies. The DMH uses several job classifications that are also administered under LEAP.

CALIFORNIA WORK OPPORTUNITIES AND RESPONSIBILITY TO KIDS (CALWORKS)

On August 11, 1997, the Governor signed Assembly Bill (AB) 1542 into law, which is the primary vehicle used to overhaul California's existing welfare program operating under the authority of the federal Temporary Assistance for Needy Families (TANF) program. This bill replaced the Aid to Families with Dependent Children (AFDC) and the Greater Avenues to Independence (GAIN) programs with the CalWORKs program. Under CalWORKs, cash aid to families is time-limited and able-bodied adults in the family must meet certain work requirements to remain eligible. County welfare departments, under the supervision of California Department of Social Services (CDSS), administer CalWORKs. Mental health services, to reduce barriers to employment, are a critical component of CalWORKs.

The major focus of CalWORKs is to prepare clients for work and assist them to obtain and maintain employment so they can effectively support their families. The State Legislature determined mental health and substance abuse treatment are necessary components of CalWORKs and included the provision of these services in the law. To the extent that funding is available, counties will provide for the treatment of mental or emotional difficulties and substance abuse that may limit or impair a client's ability to make the transition from welfare to work or retain employment over a long period of time. Available mental health services must include assessment, case management, treatment and rehabilitation services.

County welfare departments and the county mental health departments are mandated to jointly develop mental health assistance services. CalWORKS also requires county welfare departments and the county alcohol and drug departments to collaborate to ensure an effective system is available to provide for evaluations and substance abuse treatment. In addition to ongoing technical assistance, CDSS maintains oversight of the funding through reports submitted by the county welfare departments. The DMH provides assistance by participating in interagency meetings with California Department of Alcohol and Drug Programs, CDSS, and other State agencies. This interagency workgroup is dedicated to sharing information about new financial support sources, technical assistance, research, and program and policy development.

The primary funding source for the CalWORKs program is the federal TANF Block Grant. CDSS is the lead agency that draws down and distributes the federal funds to county welfare departments. There is a State and County Maintenance of Effort (MOE) for the TANF Block Grant. General Funds (GF) for CalWORKs substance abuse services and mental health services are $48,870,000 and $59,916,000, for FY 2005-06, respectively, $ 48,125,000 and $62,777,000 for FY 2006-07. These funds are used to meet the TANF Block Grant MOE requirements.

Reporting on the number of CalWORKs clients receiving mental health and substance abuse treatment services began in 1999. The report includes the number of clients referred for and receiving mental health and/or substance abuse treatment services during the month. In addition, counties are required to report the mental health CalWORKs services to the Client and Services Information System (CSI).

OTHER SUPPORT PROGRAMS AND SERVICES

Self-Help

DMH assists clients and families in the "development and strengthening of community support and self-help networks," as specified in the WIC, Section 4340. Self-help is defined as a mutual support effort by a group of people who come together to share common concerns about problems that disrupt personal life. Group members help one another to cope more effectively by providing psychological support and by exchanging information and resources.

Self-help can take many forms. In addition to mutual support groups, mental health consumers have established self-help centers that offer a variety of services to mental health clients, including clients who are homeless or have recently been discharged from a state hospital. These programs are not directly funded by the State; however, many receive funds from county mental health programs as well as federal grants, e.g., Projects for Assistance in Transition from Homelessness (PATH). In SFY 2004-05 DMH supported a statewide conference call and face-to-face meetings to explore self-help and peer-operated services as Medi-Cal reimbursable activities. A Workgroup representing consumers directly involved in running self-help and peer-operated services explored methods for funding and reimbursement of these efficient and cost-effective services. The Self-help Medi-Cal Workgroup developed a manual titled *A Study of Self-help Medi-Cal: Synthesis of Workgroup Proceedings, Resources and Materials*.

To aid self-help and peer support initiatives, DMH provides funding through contracts to support organizational efforts of the California Network of Mental Health Clients (CNMHC) and NAMI California (National Alliance for the Mentally Ill). DMH continues to support the CNMHC annual statewide client forum. The purpose of the forum is to educate and share information with the members on current mental health issues. CNMHC is organized by region. The regional approach ensures broad and active participation of CNMHC membership in determining its direction and goals, and in facilitating necessary changes to the by-laws and election of local representatives to the CNMHC Board. To support the regional process and ensure participation, each region submits a self-help proposal to the CNMHC Board for review, approval and funding. These proposals, which were funded in SFY 2004-05, are in the areas of self-help and mutual support groups; public education and policy; cultural competency and sensitivity; membership outreach and networking; and job development. The regional projects in the current contract include community education and outreach through public presentations about mental health issues, stigma and discrimination; outreach and support for mental health clients in State Hospitals, Board and Care Homes, Institutes of Mental Disease, jails and isolated rural areas; client advocacy training; discharge planning; seclusion and restraint training; and activities promoting the concepts of self-help and recovery. This expansion of self-help services to clients throughout the State reflects the goal of a consumer-driven system based on empowerment.

In SFY 1995-96, with DMH support, NAMI California introduced the *Journey of Hope* program, now called *Family-to-Family*, which provides two components. One is a 12-week educational series to describe the disorders, medications, treatment, and coping skills for families of persons with serious mental illness. The second is the Support Group component, which trains participants to facilitate family support groups that reinforce coping skills, practical information, and the knowledge that they are not alone and that there is hope. The program relies on

volunteer family members as educators and peer support group facilitators to provide practical and emotional support for family members who must cope with the difficulties of their ill relatives. Training sessions were held in both Northern and Southern California in SFY 2004-05 and approximately 134 family members received training, with the following breakdown: Family-to-Family South training - 25 teachers, and Rural Outreach training - 96 teachers. These figures include a Spanish Language Outreach training -13 teachers. These family members and other teachers then provided education classes to approximately 2,233 family members statewide. Additionally, another 19 individuals were trained to facilitate family support groups, the second component of *Family-to-Family*. These individuals and other facilitators then facilitated support group meetings that included approximately 4,000 family members statewide. It is anticipated that DMH will continue to fund this training SFY 2005-06.

California AIDS Project

The DMH has responsibility for the California Aids Project. The project provides mental health counseling and support to those affected by, or at risk of, the HIV virus and AIDS. The main focus of the program is to provide counseling and mental health services to support people who are HIV/AIDS Positive, at risk of AIDS/HIV and the partners and family members needing mental health services, counseling and support for AIDS/HIV and related concerns.

Currently DMH contracts with fourteen agencies to provide these services. The range of these counties and agencies extend from San Diego County to Sacramento County. Some of these agencies are county mental health departments while others are non-profit or private service agencies. Some counties subcontract with agencies in their surrounding county.

The Budget Act of 1988 allocated $1.5 million dollars to DMH. That funding is also counted toward the match requirement for the federal Ryan White AIDS funding. The funding has remained constant for over fifteen years and is awarded on a three-year cycle from the State General Fund. The counties or agencies reapply to renew their contract near the end of the third FY. Agencies are required to submit a scope of work plan, budget detail and narrative at the time they renew their contract with DMH.

There are numerous ongoing challenges related to the provision of AIDS/HIV supportive services including a sharp rise in AIDS/HIV and resulting increased demand for services as well as the shift and change in the character of the risk groups. It is estimated that there will be a one in four new AIDS/HIV infections reported each year, in youth ages 13-21, and these youth will not be accessing services in proportion to their rising infection rates. As of November 30, 2005, California has received case reports for 139,094 AIDS diagnoses and 39,717 HIV infections. White males, age 25 or older at diagnosis, account for most AIDS (N=73,531) and HIV (N=16,398) case reported to date. Fifty-eight percent (58 percent) of individuals reported with AIDS are known to be deceased. Due to this large number, some innovative approaches have developed and been considered, such as services based upon the Harm Reduction Model which can utilize such controversial strategies as the needle exchanges for IV drug users who are high risk of AIDS/HIV infection.

It is also become common practice to link other services with HIV/AIDS counseling, such as vocational services and housing.

Disaster Assistance Coordinator (DAC)

The Department of Mental Health (DMH) Disaster Assistance Coordinator (DAC) serves an important role in coordinating with various county, state, federal and other disaster response agencies relative to its emergency and disaster mandates.

The following agencies are key agencies DMH frequently collaborates with during disaster planning and response: The Federal Emergency Management Agency, (FEMA); The Substance Abuse and Mental Health Services Administration Center for Mental Health Services (SAMSHA CMHS); Governors Office of Emergency Services (OES); Department of Health Services (DHS); Department of Alcohol and Drug Programs (ADP); Department of Social Services (CDSS); Emergency Medical Services Authority(EMSA) and the American Red Cross (ARC).

The DMH provides technical assistance to County Mental Health Departments responding to emergencies and disasters through a variety of services that include problem solving, assisting with mutual aid needs, assisting counties in completing the FEMA Crisis Counseling Program grant application and implementing projects.

The DMH Disaster Assistance Unit in partnership with the Department of Alcohol and Drug Program completed the All Hazards Capacity Building Training Project May 31, 2006. This was a joint venture to develop a concept of operations to administer a behavioral health model of services used after large scale disasters.

The DMH is currently in year two of an interagency agreement with the Department of Health Services through funding from the CDC/HRSA for Bioterrorism (BT) preparedness and training for health care providers. The (BT) training project is scheduled to be completed August 31, 2006.

DMH Headquarters County Operations Sections

County Operations is a unit within the DMH Systems of Care Division. The unit's staff is organized regionally, with the "North" section staff assigned to two main sub-regions: 1) Northern Region- primarily rural counties in the northern part of the state, and 2) Bay Region-the counties comprising the greater San Francisco Bay Area. The "South" section staff are also sub-divided and assigned to cover two main sub-regions: 1) Central Region- which includes most of the counties in California's Central Valley and many in the Sierra Nevada foothills, and 2) Southern Region- serves the large population base represented by southern California counties.

From a broad perspective, the primary goals and objectives of the DMH County Operations Unit include assisting and supporting California's county-organized community mental health programs in meeting their programmatic goals to provide high quality public mental health care. This assistance and support occurs primarily through established collaborative relationships with ongoing close communications between County Operations staff and the administrative staff of each county mental health program. Indeed, County Operations staff serves as the primary contact point between DMH and the counties. In its day to day functioning, County Operations staff provides consultative and technical assistance services to county mental health programs in

a wide variety of subject areas, from managed Medicaid ("Medi-Cal") mental health to SAMHSA, from contract monitoring to policy, fiscal, and regulatory consultation. In the event the questions or issues raised by the county indicate a need for coordination or connecting/brokering to other resources, County Operations staff also serves the important liaison role of connecting county staff to the appropriate DMH resources of people and/or information best suited to assist the county. The County Operations liaison role is also bi-directional, with county mental health programs often supplying information to DMH to assist in the development of responsive and relevant statewide programs and policy.

Specifically, though not an all-inclusive list, County Operations staff:

- Exchange information with county mental health program staff;
- Advocate for local mental health program issues;
- Respond to local mental health program inquiries, providing consultation, information, technical assistance and guidance;
- Conduct visits to county mental health programs statewide;
- Participate on a wide variety of stakeholder committees and attend meetings;
- Provide input and perspective to DMH policy development that is enriched by County Operations' uniquely close relationship with, and understanding of, counties' specific mental health program needs, concerns and experiences;
- Review and approve mental health plans and modifications to plans;
- Develop, review, and approve county performance contracts;
- Facilitate timely and accurate county program reporting;
- Provide consultation to county mental health programs on federal and state laws, regulations, and policies;
- Assist county mental health programs in achieving quality improvement goals;
- Assist county mental health programs in achieving cultural competence goals;
- Collaboratively analyze, develop and implement problem-solving strategies on issues identified by county mental health programs; and
- Work directly with counties mental health programs, stakeholders and consultants towards implementation of the MHSA's Community Services and Supports Plans for each county.

ADULT AND OLDER ADULT PERFORMANCE OUTCOMES

The design and implementation of appropriate performance measurement systems are critical components of the transformational agendas reflected in the President's New Freedom Commission Report on mental illness, the Institute of Medicine's Six Aims for Improvement and California's Mental Health Services Act[1] (MHSA). To ensure measurement systems are consistent with the recovery/wellness-based philosophies for adults and older adults, modification of evaluation strategies is expected over time. California continues to align itself and participate in performance measurement designs at the national level to keep its measurement strategies consistent with Federal reporting requirements such as the Uniform Reporting System (URS) [supported in part through the Data Infrastructure Grant (DIG)], and the National Outcome Measures (NOMS). Additional detailed information on performance

[1] http://www.dmh.ca.gov/MHSA/docs/meeting/12-17-2004/Mental_Health_Services_Act_Full_Text.pdf

measurement and the MHSA for California's public mental health system is available on the DMH website at http://www.dmh.ca.gov/poqi/ and http://www.dmh.ca.gov/MHSA/default.asp, respectively.

During SFY 2005-06, DMH continued to use the Web-Based Data Reporting System (WBDRS) to collect data using a point-in-time method to target all consumers receiving face-to-face mental health services. The DMH Consumer Perception Survey was conducted during a two-week period in November 2005 and May 2006. Again, the most recent version of the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey was used to assess perceptions of quality and outcomes of care. The surveys are currently available in English, Spanish, Korean, Tagalog, Chinese, and Vietnamese[2].

In addition to the Consumer Perception Survey, California's MHSA has provided support for transforming California's Mental Health System to provide a more comprehensive approach to the development of community based mental health services and supports for the residents of California. With respect to performance outcomes, this approach includes an emphasis on accountability to measure performance, as well as to improve quality and align management and administrative practices with quality services, productivity and positive outcomes.

Since the design of performance measurement systems is a highly complex endeavor, DMH assembled a Performance Measurement Advisory Committee (PMAC) to advise DMH regarding technical issues related to performance measurement such as selection of indicators, assessment tools and other protocols for data collection, as well as information systems/software design and development for data collection, management, analyses and reporting. Selection of PMAC members was based on type and level of experience, areas of expertise and collective ability to represent the diverse persons and geographic areas within California.

To set a framework for designing performance measurement systems, DMH developed a Tri-Level Performance Measurement Paradigm,[3] which is being used to develop measurement strategies at the public/community impact level, the mental health system accountability level and at the individual client level. This paradigm is being used by the PMAC to design measurement methods at each level. As a starting point, the PMAC is currently focused on implementing performance measures at the individual client level.

Based on the successful Integrated Services for Homeless Adults with Serious Mental Illness (AB 2034) evaluation model[4], the PMAC developed initial requirements for measuring individual-level performance outcomes for a small, selected target population, called Full Service Partners (FSPs), as specified in the DMH *"Mental Health Services Act Community Services and Supports, Three-Year* Program and Expenditure Plan Requirements, Fiscal Years 2005-06, 2006-07, 2007-08[5]". For all FSPs identified and served, providers must submit the data captured by three types of assessments: a Partnership Assessment Form, a Key Event Tracking and a Quarterly Assessment[6]. The Partnership Assessment Form gathers history and

[2] The Consumer Perception Surveys are posted on the DMH website at http://www.dmh.ca.gov/POQI/perception_survey.asp

[3] For more information, visit http://www.dmh.ca.gov/mhsa/docs/Perf%20meas%20document%20for%20posting%205%2012%2005.pdf

[4] http://www.ab34.org/

[5] http://www.dmh.ca.gov/mhsa/docs/CSSfinal_8.1.05.doc

[6] View the assessments at http://www.dmh.ca.gov/POQI/full_service_forms_POQI.asp

baseline information about each FSP and the Key Event Tracking and the Quarterly Assessment gather follow up information. The domains that are tracked by these assessments include residential setting, education, employment, sources of financial support, legal issues/designations, emergency interventions, health status and substance abuse.

A new information technology solution has also been developed that supports the collection of the repeated-measures, FSP accountability data which described above. The Data Collection and Reporting System (DCR) is California's first module toward Electronic Health Records (EHRs) for the public mental health system. The DCR is aligned within the State's vision for a comprehensive, interoperable electronic mental health record system. By leveraging Extensible Markup Language (XML) technology, DMH will be able to exchange, manage, and integrate data, as well as distribute information system changes. This solution offers both a centralized, web-based application and methods that ensure interoperability between disparate county/provider systems. The DCR was designed by using a hybrid data model that combines (1) the traditional relational data model, maximizing performance and scalability with (2) support for the XML data type to ensure system flexibility to changes in business/data needs. Consistent with DMH's vision for a comprehensive and fully interoperable information system, DMH also expects to incorporate the existing WBDRS within the DCR to provide continued support for survey administration methods, including those used to report MHSIP Consumer Perception Survey data.

STATE QUALITY IMPROVEMENT COUNCIL

The State Quality Improvement Council (SQIC) assists the California Department of Mental Health (DMH) in continuously improving the quality of mental health services in the public mental health system. Appointed by the Director of DMH, the SQIC is comprised of DMH staff, local mental health department staff, clients, family members, advocates, and other stakeholders who work on quality improvement projects toward the goal of system transformation. Within the transformational agenda, quality improvement projects are undertaken to develop a system that is client and family centered, culturally competent, accessible, responsive, efficient, effective, and incorporates recovery/resiliency/wellness-based philosophies.

Current national and state trends have resulted in the development of guidelines and recommendations for system improvements and transformation. These include the Six Aims for healthcare delivery and quality care discussed in the Institute of Medicine's Crossing the Quality Chasm's (2001), the six goals for a transformed mental health system discussed in the President's New Freedom Commission Report on Mental Illness, the Mental Health Statistics Improvement Program (MHSIP) Quality Report Toolkit, the National Outcomes Measures, and the Uniform Reporting System, supported by the Data Infrastructure Grant. The State Quality Improvement Council is using many of these guidelines and recommendations. One example of the Council's work is the development of a "crosswalk" translating the Six Aims of the Institute of Medicine's Crossing the Quality Chasm's report into applicable Aims for mental health delivery and quality care.

Many exciting changes in California's public mental health system are currently being introduced as a result of the passage of Proposition 63 in November 2004, now known as the Mental Health Services Act (MHSA). Since passed, the DMH in conjunction with numerous

stakeholders have conceptualized a transformed mental health system based on wellness and recovery principles. The MHSA philosophy especially reflects the importance of processes that are client and family driven and that are individualized to provide "whatever it takes" activities in support of recovery.

The State Quality Improvement Council reviews data, processes and other information, and recommends strategies to bring about quality change. The council's focus is on quality improvement and quality promotion. The SQIC is being reinvigorated with new methods and a new focus in order to meet the challenges of the transformative process being instituted in state and local public mental health systems per the MHSA. This new focus builds on the previous work of the SQIC, and serves as an example of the quality improvement process.

To accomplish its mission, the Council collaborates with existing quality-related committees and councils such as the Compliance Advisory Committee, the External Quality Review Organization, the Performance Measurement Advisory Committee, the California Mental Health Planning Council, and the County Mental Health Directors Association. The Council also reviews data gathered by Medi-Cal claims, the Client and Services Information System, and the Statewide Performance Outcome Measurement System, etc. to identify successes and problems related to quality processes. In this way, the SQIC acts as a feedback mechanism to suggest process improvements and interventions that will generate added and/or improved quality across mental health systems

Finally, an important goal of the SQIC is to provide education about the interpretation and contextualization of data and other information. As a result, participants and other interested parties improve their understanding of data. Through the increased understanding of data, speculation about what data means is reduced, decision support is improved, and the design of subsequent quality improvement processes is enhanced.

EXTERNAL QUALITY REVIEW ORGANIZATION

The External Quality Review Organization (EQRO) will objectively assess quality, outcomes, timeliness of and access to the services provided by 56 California Mental Health Plans (MHPs) that contract with the Department of Mental Health (DMH) to provide Medi-Cal specialty mental health services to Medi-Cal eligible individuals. To make this assessment, the EQRO will conduct annual external quality reviews that include:

- Assessment of DMH-specified Performance Measures (PMs).
- Assessment of MHP-selected Performance Improvement Projects (PIPs).
- Periodic evaluation of selected aspects of each MHP's on-going internal Quality Improvement (QI) system and annual review of each MHP's progress on any related plans of correction.
- Review of each MHP's health information system capability to meet the requirements of the Medi-Cal specialty mental health services program.

- Review of each MHP's most recent compliance review performed by the DMH Program Compliance Division, Medi-Cal Oversight Unit, and each MHP's progress on any related plans of correction.

The EQRO will prepare a report annually on each MHP that comprehensively assesses the overall performance of the MHP in providing mental health services to Medi-Cal beneficiaries. The individual MHP reports will utilize the EQRO's own assessment of each MHP in light of the review components described above. EQRO will also prepare an aggregate report for the State based on the information gained in the assessments of the individual MHPs.

The EQRO will provide up to four hours of technical assistance and consultation for each MHP annually. The intent of this activity is to meet the individualized quality improvement needs of each MHP and to maximize the utility of the external review activity as a quality improvement learning experience.

Because of the unique nature of the Medi-Cal managed mental health care system, calculation of performance measures is done by DMH using claims data obtained from the MHPs. Thus, in order to fully assess MHP performance, the EQRO will review and assess various DMH data systems and processes in addition to the MHPs' system for reporting claims data. The EQRO will prepare an annual report that comprehensively assesses the overall performance of DMH in this capacity.

The first year of reviews will utilize protocols for validation of performance measures and performance improvement projects and an information system assessment instrument developed by DMH, in addition to any review protocols or instruments developed by the EQRO for use in other areas of the review. In subsequent years, the EQRO will work with DMH, MHPs and other stakeholders to edit the DMH-developed protocols and information system assessment instrument as necessary to maximize their effectiveness in collecting pertinent information to meet regulatory requirements and adapt their content to the California public mental health system.

In order to successfully accomplish the above the EQRO will be required to work closely with the DMH Contract Administrator and other key DMH staff as needed to plan and coordinate activities. The EQRO will also be expected to attend up to four statewide meetings annually to provide training and technical assistance on the EQR process to MHPs and other stakeholders. Periodic status reports will be required by DMH.

State Plan for Comprehensive Community Mental Health Services for Adults and Older Adults

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

State-Level Performance Indicator Description

Goal:	To create a comprehensive community mental health system that promotes recovery and wellness for adults and older adults with serious mental illness (SMI).
Objective:	By June 30, 2007, counties throughout California will have established Full Service Partnership programs to provide recovery-focused, comprehensive services, including mental health and other community support services, to previously un-served or at risk individuals. By June 30, 2007, DMH will establish a process for tracking the actual number of individuals served quarterly in Full Service Partnership programs established with Mental Health Services Act funds and report that information in the State Implementation Plan.
Population:	Adults and older adults diagnosed with SMI
Criterion:	Comprehensive Community-Based Mental Health Service Systems
Brief name:	Full Service Partnerships
Indicator:	Number of individuals enrolled in FSP's
Measure:	Number of FSP's
Source(s) of Information:	Quarterly Actuals submitted by counties
Special Issues:	
Significance:	Full Service Partnership programs established pursuant to the MHSA are expected to deliver the most comprehensive array of services available based on an individual's specific needs. These programs may use MHSA funds to provide "whatever it takes" to help persons achieve their goals and improve the quality of their lives. Services are not limited to mental health services but are expected to address other needs including but not limited to housing, employment, education, co-occurring conditions, physical health, involvement with the criminal justice system, etc. It should be noted that counties are required to collect and report individual outcome information on persons served in Full Service Partnership programs, including their housing and employment status.

Fiscal Year: 2007

Population: Adults and Older Adults with SMI

Criterion: Comprehensive Community-Based Mental Health Service Systems

(1) Performance Indicator:

1: CSS Plans

(2) FY 2005 Actual Not applicable.

(3) FY 2006 Project Not applicable.

(4) FY 2007 Objective By June 30, 2007, counties throughout California will have established Full Service Partnership programs to provide recovery-focused, comprehensive services, including mental health and other community support services, to previously un-served or at risk individuals. By June 30, 2007, DMH will establish a process for tracking the actual number of individuals served quarterly in Full Service Partnership programs established with Mental Health Services Act funds and report that information in the State Implementation Plan.

(5) % Attain

Criterion 1: Comprehensive Community-Based Mental Health Service System

Name of CMHS National Outcome Measures: 2-a. and 2-b. Reduced Utilization of Psychiatric Inpatient Beds – Readmissions to State Psychiatric Hospitals within 30 Days and 180 Days

Population: Adults and Older Adults with SMI

California has not set specific goals to date because the absolute and relative numbers of persons served in State Hospitals is very low. A recent NASMHPD report shows that California's State Hospital utilization for voluntary and civil commitments is among the lowest in the country. The number of hospital days per 100,000 children and youth is 444 while the national average is 1,590. This is the second lowest rate among 30 states reporting. The rate for adults in California is 918 while the national average is 5,360. This is the third lowest rate among 39 states reporting for adults.

The performance indicator is stated as the percent of persons discharged who are readmitted. As the number of civil commitments in the State Hospitals continues to decline, the number of discharges also declines, and hopefully the number of readmissions also declines. However, when the numbers are small, a difference of one or two people can change the direction of readmissions from decreasing to increasing. Following are data from the Block Grant application to illustrate this point.

Readmission to State Psychiatric Hospitals within 30 Days for Adults

Fiscal Year	2003-04 Actual	2004-05 Actual	2005-06 Target
Performance indicator	3.5%	8.9%	8.9%
Numerator	9	12	12
Denominator	254	135	135

Readmission to State Psychiatric Hospitals within 180 Days for Adults

Fiscal Year	2003-04 Actual	2004-05 Actual	2005-06 Target
Performance indicator	5.1%	10.4%	10.4%
Numerator	13	14	14
Denominator	254	135	135

The Department cannot establish a goal to which the state will be held based on so few people. The Department can state that it will strive to decrease the readmission rates, and that there is a goal to keep the readmission rate below 15 percent. This would allow for variation that might take place in individual years.

In addition to the instability of trends based on so few people, there are serious program concerns. At some point, there are a minimum number of beds that must be maintained for persons who are seriously ill and who require 24-hour services for an extended period of time. The people who use these beds are very seriously ill, and typically there are no other options in the community. Therefore, it is not surprising that a certain number may return to the hospital, despite county efforts to keep them out of the hospital. Perhaps a different approach is needed for states where the state hospitalization rate is very low.

Criterion 1: Comprehensive Community-Based Mental Health Service System

Name of CMHS National Outcome Measures: 3. Evidence-Based Practices

Population: Adults and Older Adults with SMI

Combining the resources from the Data Infrastructure Grant (DIG) and the Mental Health Services Act (MHSA), the Department has modified its data systems to enable the reporting of Evidence–Based Practices (EBP). These changes were combined with other changes that were needed to the data system. They are being implemented for SFY 2006-2007. Since 58 county systems are being modified to report these new data elements, we expect some lag in reporting over the next fiscal year. The Department developed the reporting guidelines and standards last fiscal year and has been aggressively training counties by Web conference and regional in-person trainings. These trainings are intended to guide and direct counties on making system modifications. Training and technical assistance are a significant component of the second DIG grant for FY 2006-07 to ensure accurate data collection and reporting. During FY 2006-07 as counties start reporting, the Department will continue to provide technical assistance to counties as they implement the changes and monitor reporting to identify any reporting problems early. The Department expects to report limited baseline data for FY 2006-07.

Criterion 1: Comprehensive Community-Based Mental Health Service System

Name of CMHS National Outcome Measures: 4. Client Perception of Care

Population: Adults and Older Adults with SMI

Fiscal Year	2003-04 Actual	2004-05 Actual	2005-06 *Estimate*	2006-07 Target
Performance Indicators	70.1% (+/- 1%)	70.1% (+/- 1%)	69.1% (+/- 1%)	70% (+/- 1%)
Numerator	13,654	32,251	30,676	
Denominator	19,469	46,031	44,392	

California continues to assess consumer perception semi-annually during the months of May and November. As expected, client perception of care remained consistent between FY 2003-04 and FY 2004-05. The estimate for FY 2005-06, based on preliminary data, also remains at approximately 70% (+/- 1%). The estimates for the numerator and denominator, above, are arrived at by doubling the numbers from our November 2005 data collection period. A May 2006 survey collection was conducted, however data from these surveys are not yet available for analysis. The target for FY 2006-07 is to maintain the (approximate) 70% positive response rate of the 2003-04, 2004-05, and 2005-06 fiscal years.

These data are used in reports to the counties throughout California to report on clients' perceptions of care. The California DMH encourages counties to use this information locally to make program improvements to benefit clients and family members. Additionally, the data are used to inform California's many stakeholders such as the State Quality Improvement Council, California Mental Health Planning Council, Performance Measurement Advisory Committee, and the newly established Oversight and Accountability Commission for Mental Health Services Act statewide performance oversight processes.

CRITERION 2. MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY

- **The plan contains quantitative targets to be achieved in the implementation of such system, including the numbers of such individuals residing in the areas to be served under such system.**

- **The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and older adults.**

OVERVIEW OF CALIFORNIA'S DATA SYSTEMS

There are several automated systems at the State level that contain client, service and fiscal data from State Hospitals and county mental health programs. The data systems for State Hospitals have been developed around the Admission/Discharge/Transfer (ADT) System, which is an on-line real time system for State Hospitals. The system includes basic demographic characteristics of all clients, dates in and out of the hospital, dates and types of legal class changes, and dates of ward changes. The function that tracks legal class and ward changes allows for billing and fiscal reporting since there is a daily rate established for each ward. Data from the ADT system are linked with the Cost Recovery System to generate billing data. A number of other functions have been automated that tie to the ADT system, such as Trust Accounting, Pharmacy, Laboratory, and Physician's Orders. There are plans to continue data system development to support increased efficiency in State Hospital operations.

Wellness And Recovery Model Support System (WARMSS)

The WARMSS is a comprehensive computer software program that records each patient's assessed needs as derived during initial treatment team planning sessions; patient-generated life goals; goals for each treatment session or class; available types and providers of treatment; a schedule and rosters of patients assigned to treatment sessions; degree of patient achievement of each treatment goal; changes in goals; and measures of progress in treatment. When WARMSS is deployed system-wide, DMH will be able to monitor and summarize data concerning amounts and types of treatments provided and the effectiveness of these treatments. The system is consistent with the wellness and recovery models of mental health that place special emphasis on client-driven treatment goals and services and in which services are often provided in treatment malls with a campus atmosphere and flexibility in tailoring available treatment to individual needs. WARMSS was installed at Metropolitan State Hospital in April 2005 and will be deployed in all state hospitals by early 2006.

Recovery-Model Outcome Reports (formerly "SHOES")

Long Term Care Services will combine data generated by the WARMSS system with other centrally gathered data to write reports that were formerly conducted as part of the State Hospital Outcome and Evaluation System (SHOES). The SHOES project was redesigned in the past year to be consistent with the Recovery Model of mental health treatment that the Department of

Mental Health has adopted. Long Term Care Services will write monitoring and evaluation reports that expand upon the current "Questions and Answers About the Safety and Effectiveness of California State Hospital Services" report series begun in September 2004 to answer questions including:

- What proportion of patients met their goals for mental health recovery?
- What treatments were provided to patients who met and did not meet goals?
- What system results are achieved (reductions to length of stay and return rates)?

While the operational data systems for State Hospitals have been developed by and are maintained by DMH staff, county mental health programs each develop their own systems and send extracts from their systems to DMH in specified formats. There are two primary data systems used for county mental health data. The Client and Service Information (CSI) system is a statistical reporting and includes client and service information about all persons served in county mental health programs. The Medi-Cal system is actually composed of several files that include all persons who are eligible for Medi-Cal, and the Medi-Cal claims that have been paid for specialty mental health services.

Both of these systems are used extensively by DMH staff to calculate indicators for the Statewide Quality Improvement Committee, for program planning, monitoring, and to respond to requests from the legislature, state and federal agencies, county programs, consumers, family members, and other interested stakeholders.

In addition to client level data systems, there are two other systems that include county data. The County Financial Reporting System (CFRS) is a year-end cost report of all costs expended by county mental health programs. Costs are reported in the same categories that are used for statistical reporting. The Provider and Legal Entity File identifies the actual provider site as well as the legal or corporate entity, or county, that "owns" the provider. The CSI system is based on provider reporting while the CFRS is based on legal entity reporting. Through the Provider and Legal Entity file, costs reported to the CFRS by legal entity can be linked to services reported in the CSI by provider. Through this linkage process it is possible to estimate the cost of services provided to specific groups of individuals, such as youth, or people with certain diagnoses. Preliminary efforts to link the data sets for several projects have proven to be challenging. There are frequently minor differences in spelling of names or transpositions of dates that cause records not to match when they should. DMH staff will continue to work in this area to improve the matching process so that the benefit of linking the data systems can be realized.

As the data systems are fully implemented and integrated, their use is increasing. With the increasing use of the data, the importance of complete and accurate data also increases. The DMH will be developing a data quality program focusing on CSI to ensure the accuracy of the data.

Health Insurance Portability and Accountability Act

The DMH continues efforts on the implementation of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). The provisions require establishment of national standards for electronic health care transactions and national

identifiers for providers, health plans, and employers along with the security and privacy of health data. Adopting these standards improves the efficiency and effectiveness of health care systems by encouraging use of electronic data interchange (EDI).

When a HIPAA rule becomes final, DMH (as health plan and healthcare provider) has two years to achieve compliance. DMH compliance efforts have included a series of information exchanges and interactions with business partners to establish implementation guidelines.

- The Privacy Rule was final In December 2000, final modifications were released in August 2002, and the compliance date was April 2003. DMH met the compliance date. Privacy training was provided to DMH staff at headquarters and all State Hospitals. The Notice of Privacy Practices form was provided to each DMH State Hospital patient and posted on the DMH website. The Authorization for Release of Information form was updated to meet HIPAA requirements and is available at each State Hospital.

- The TCS rule was final in October 2000 and final modifications were released in February 2003. DMH requested and was granted a compliance extension to October 2003 (which DMH met). The State is using a phased-in approach to achieve HIPAA compliance for the Short-Doyle Medi-Cal claims processing system. Phase I implementation was achieved by using a translator to convert inbound HIPAA compliant claim transactions (837) to the proprietary SD/MC claim format used by the Department Health Services- Information Technology Short-Doyle (DHS-ITSD) claims processing system and return a HIPAA compliant payment/remittance advice (835). Phase II development is anticipated to begin in December 2006 and implemented in July 2008.

- The Security rule was final in April 2003 with a compliance date of April 2005. DMH is continuing to remediate areas identified in the January 2004 gap analysis document.

- The National Provider Identifier (NPI) rule was final January 2004, with an effective date of May 23, 2005 and a compliance date of May 23, 2007. An assessment, gap analysis, and requirements plan was completed in May 2006. DMH began remediation efforts in June 2006 and is on schedule to meet the compliance date.

DMH'S APPLICATIONS DEVELOPMENT SECTION

DMH's Applications Development (AD) Section is divided into three units: Hospital Services, County Services and Headquarters Services. The following is a brief description of some of the systems each unit is responsible for:

State Hospital Services

This unit responds to the diverse business needs of the staff working in various capacities throughout the five State Hospitals. The systems they develop and maintain facilitate key hospital functions to assist in the care and treatment of approximately 5,000 patients. These systems are deemed mission critical by the DMH and interface with systems in other agencies.

The following are Hospital Services systems that are either maintained or under development by the AD section:

Admission Discharge and Transfers (ADT) - The ADT System performs State Hospital census functions. Statistical information from this system is used for management reporting and research purposes. The system provides transactions to the Department of Developmental Services (DDS) for billing purposes.
ADT contains the patient file, which is the foundation for all patient care-related hospital systems, and vital criminal and clinical history data. The system has over 500 screens and 400 standard reports. When a patient is transferred from one hospital to another, patient data is available to the new hospital. This is essential for both the patient and staff at the hospitals.

Master Billing Project (MBP) - Provides a mechanism to capture Fee-For-Service (FFS) billing information within existing and future DMH HAS applications. An automated Patient Progress Note (PPN) will help facilitate the doctors completing the documentation that is required for billing. After validation of billing this information will be passed to the DDS Cost Recovery System (CRS) for billing.

Additionally, it will enhance the Master Formulary and create Drug Utilization Review tables for the Pharmacy Hospital Operations system and Physicians' Orders System (described below). This will allow for much needed order validation using the patient's diagnosis, medical condition, and medication regimen for indications and contraindications, appropriate dosing levels and duration of therapies as well as other valuable special conditions and precautions.

Pharmacy Hospital Operations (PHO) - The PHO system processes medication orders and recurring non-medication orders. It generates monthly Physician Orders for renewal and information that supports unit-dose order filling functions; this includes pick lists, Medication Administration Record forms and an electronic file for the Baxter automated unit-dose dispensing machine. All medication orders are checked for Drug-to-Drug Interactions, allergies, over maximum-dose, and approval for non-formulary items. When a patient is transferred, his/her medication orders are visible to the new hospital and can be utilized by the new physician as baseline current medications for the new episode. This greatly benefits the staff and minimizes patient risk. PHO also has over 500 screens.

Physicians' Orders System (POS) - POS automates physician order entry and transmission of physicians' orders to the service provider. This reduces order turnaround time and errors, and promotes more timely and effective patient treatment. This system uses extremely complex client/server architecture to provide the user with the easiest, friendliest interface possible. To date, approximately 700 users at Napa State Hospital are using POS to perform their daily operations. Upon complete implementation of the POS, there will be over 4,000 users within the DMH hospitals.

Service Usage Report (SUR) - The SUR is used to collect data from the ADT system and maintain files of county usage of beds at the hospitals. The system runs twice a day and produces summaries of daily, monthly and fiscal YTD bed usage totals. This system supports the County Contract Monitoring System (CCM), which reports over-contract use of State

Hospital beds, and the Fiscal Automation System (FAS) reports, which the hospital accounting offices use to comply with certain CALSTARS cost reporting requirements.

Treatment Outcome System (TOS) - The State Hospital TOS schedules patients into treatment activities, records patient and staff attendance at those activities and produces reports for managers at the hospitals. TOS reports have been used to support departmental testimony at the yearly legislative budget hearings.

Trust Accounting Cashiering System (TACS) - The TACS accounts for patients' financial assets and associated transactions. The system records receipts from patients, their families, conservators, Social Security etc., and disburses funds for patients' personal use and for reimbursing the cost of their care.

The Canteen subsystem allows the canteen operators to scan bar coded patient identification cards, determine patient account balances, apply purchases and other transactions saving operators' time.

DMH'S APPLICATIONS DEVELOPMENT SECTION

County Services

This unit supports, enhances and develops automated systems to facilitate oversight and program decisions for the 58 counties providing services to mental health consumers. The systems also perform billing, payment and report processing for Medi-Cal services and federal reporting requirements. The unit's primary customers are the System of Care staff at DMH Headquarters and the county program and technical staff. In addition to DMH systems support, the unit develops county-level applications and file extractions, responds to technical questions, and fosters DMH and county program and technical relationships.

To further the modernization of the county systems, the unit is also developing a decision support system that includes data from all related county and State systems to provide management reporting on access, cost and outcomes of mental health services across the entire continuum of mental health care. The unit is using the newest Internet technologies to securely provide confidential mental health information to all its business partners.

The county technical staff are viewed as both customers and suppliers of these systems. All systems under construction are directed by the input of county technical staff, consumers and the county vendors. Although this is a more difficult approach than previously used, there is greater county buy-in and improved county reporting.

Client and Services Information System (CSI) – The CSI system collects, edits, and reports on client demographic and service encounter information on the entire California public mental health population of approximately 500,000 people receiving 7.5 million services per year. This system works via a web browser to provide data entry and correction screens, processes batch files and returns errors with error identity, and passes data to and from the counties via the

Information Technology Web Server. The CSI data will be integrated with other data sources to facilitate decision support.

County Financial Reporting System (CFRS) – This new system will provide the DMH County Financial Program Support section with a system to process local mental health program costs, report SD/MC, realignment, and other cost revenues by legal entity and mode of service; and enable the program to have the capability to provide several data analysis reports showing summary and aggregate information. These reports are needed by SD/MC, realignment auditors, the State Legislature, and local, State, and national interest groups.

Data Collection and Reporting System (DCR) – Currently, the DCR supports the collection of repeated-measures for the initial performance measures for the Mental Health Services Act Full Service Partnership outcomes assessment. The DCR is aligned within the State's vision for a comprehensive, interoperable electronic mental health record system. By leveraging Extensible Markup Language (XML) technology, DMH will be able to exchange, manage, and integrate data, as well as distribute information system changes. This solution offers both a centralized, web-based application and methods that ensure interoperability between disparate county/provider systems.

Information Technology Web Server (ITWS) – Allows for the counties to pass data files for SD/MC, MEDS, PODS, CSI, etc. electronically to DMH as well as receive them from DMH. This greatly decreases the time required for handling and errors in the initial processing steps.

Inpatient Consolidation System (IPC) - Allows counties to view and report the inpatient claims data files provided by the fiscal intermediary (EDS) under Managed Care Phase I. Counties use this information to verify realignment offsets by DMH and reconcile paid claims with their associated Treatment Authorization Requests (TARs). DMH Managed Care and Accounting use this system to resolve county inpatient claim issues and calculate the realignment offset.

Medi-Cal Eligibility Data System (MEDS) – This file is provided to DMH monthly by the Department of Health Services (DHS). The DMH in turn provides county mental health programs with these files to conduct analyses of their risk under capitation or block grant contracts; plan allocation of their resources; identify clients who are eligible for Medi-Cal; and identify their third party insurance coverage, if any. This system also provides counties with non-resident beneficiary information upon submission of a MEDS ID. Currently, staff are analyzing a county request to perform real-time queries of the MEDS information from their county-based integrated systems.

New Institutions for Mental Disease (NIM) - The DHS is required to provide the federal CMS information on Medi-Cal beneficiaries in Institutions for Mental Disease (IMDs). This requirement is to ensure compliance with Medicaid requirements involving Federal Financial Participation (FFP) and Fee-For-Service/Medi-Cal (FFS/MC) ancillary services. In order to facilitate this requirement, this system collects the IMD information from the counties.

Omnibus Budget Reconciliation Act (OBRA) System – This system is federally mandated to refer, track and maintain the data to determine the placement and treatment for seriously mentally ill

residents in Skilled Nursing Facilities (i.e. whether they require nursing care, mental treatment, both or neither). The PASARR Section (Pre-admission Screening and Resident Review) receives Level I screening documents from the facilities and determines which ones warrant the more thorough Level II evaluation. Based on the evaluation, an appropriate letter is sent to the resident, facility, physician and field office informing them of the treatment recommendations.

Provider System (PRV) – This is an on-line application for inquiry and update of provider and legal entity data, including Medi-Cal certification information; furnishing provider validation information to the CSI system; and generating reports and files required by external entities such as EDS, DHS and all county mental health plans.

Short-Doyle/Medi-Cal System (SD/MC) - This system processes claims submitted by the counties, and initiates corrections and applicable approval processes. The volume of claims processed by SD/MC exceeds $1.5 billion annually.

SD/MC Explanation of Balances (EOB) – This is an application to view the EOB files, which contain detailed adjudicated claims information. This application was developed and is widely used by numerous counties.

Web-Based Data Reporting System (WBDRS) – The WBDRS is an integrated technology solution which was designed to improve data quality and ease the reporting of performance measurement data by counties to DMH. This system allows for direct, on-line data entry, scanning and local data verification, and batched data upload. The submitted data are used to evaluate the quality and increase the effectiveness of mental health services for California's clients and their families.

DMH Headquarters Services

This unit supports multiple divisions at Headquarters through the development of standalone and server-based applications to facilitate tracking efforts and increase efficiency of day-to-day operations. Below are a few of the systems supported by the AD section:

Conditional Release Program (CONREP) - The CONREP system records patient data, provider contract information, and services received. This information is used to reimburse service providers, monitor service units and dollars, track patients and treatment compliance, and evaluate the effectiveness of the program that provides community-based services for the judicially committed. An interface with the Department of Justice provides access to criminal history data. Statistical reports are used to notify the Legislature of program status, as well as for program monitoring and fiscal planning.

Jamison/Farabee Program - The Jamison/Farabee system was developed to track court-ordered quarterly medication reviews of patients who have been diagnosed as "Gravely Disabled." The database contains both patient and quarterly review data. The monthly statistics report summarizes the monthly review data by Review Type and Review Status. Monthly compliance checks, certified competent to consent and Rx Review counts are also included in the report. The Print Reviews report is a report of patient reviews that were completed within a date range.

The report includes Reviewer Name, Review Date and Patient Name, Patient ID, Unit # and Patient's Physician. The Non-Participant report is a list of all patients who have been terminated from the Jamison/Farabee review process.

Mentally Disordered Offender System (MDO) - The law requires that a prisoner who meets six specific MDO criteria shall be ordered by the Board of Parole Hearings to be treated by the DMH as a condition of parole. The MDO system provides a comprehensive method of tracking MDO patients from the California Department of Corrections and Rehabilitation (CDCR) referral to CONREP discharge. The automated evaluation scheduling facilitates prioritization of evaluations to be conducted and references to previous evaluation results. Aggregate data regarding referrals, clinician activity, evaluation results, State Hospital population, CONREP population, and CDCR facilities are also provided.

Ombudsman's Services Data System (OSD) – This system was developed to provide a means of tracking calls received from Medi-Cal beneficiaries and/or their representatives who have questions, concerns, or complaints about their coverage. The system tracks beneficiary and representative information, and categories of issues such as accessibility, benefits/coverage, and quality of care. The system gives the Ombudsman the ability to keep notes on the nature of the call and any follow-up calls, and to record when the case was resolved and what kind of conclusion/resolution was reached.

Sexually Violent Predator System (SVP) – The SVP data system consists of several linked Microsoft Access databases containing information on potential SVP inmates referred from the CDCR and screened by DMH. The systems include inmate demographic/I.D. data, SVP record review and clinical evaluation data, DMH and "post-DMH" tracking information, research-related data, SVP evaluation accounting information, and State Hospital SVP commitment data. Portions of this data are available to Atascadero State Hospital, Coalinga State Hospital, Board of Parole Hearings, and CDCR via DMH's Information Technology Web Services (ITWS).

Treatment Authorization Request - Level II (TAR Level II) - The TAR Level II tracks the provider appeal process. The system contains the date the appeal is received, sends letters requesting documentation and substantiation from the providers, tracks when information is received, notes whether the decision was upheld or reversed, and generates the appropriate information letter regarding the appeal to the provider.

CALIFORNIA'S DEFINITION OF TARGET POPULATION

California's Welfare and Institutions Code, Section 5600.3 (b) (2) defines "serious mental disorder" as follows:

"For the purposes of this part 'serious mental disorder' means a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder."

PREVALENCE METHODOLOGY

A number of needs assessment methodologies have been used in the past by the DMH. In the late 1980s, the DMH contracted for a needs assessment study with Dr. Ken Meinhardt and his collaborators. They used rates from the Epidemiological Catchment Area (ECA) Study and applied them based on the demographics of California's counties. This resulted in a rate for major mental disorders of 6.15 percent for adults. In 1993, the DMH again contracted with Dr. Meinhardt for a prevalence study based on the criteria for the target population that were specified in law. They were very restrictive and defined the target population based on diagnosis, functioning level, duration of disorder, and likelihood of being eligible for public assistance. This resulted in a rate of 1.6 percent, which was used for several years. However, since then, the DMH and county mental health programs have taken on increased responsibility to serve populations beyond the target population. For example, with the consolidation of Medi-Cal mental health specialty services, clients who meet medical necessity must be served. Also, California's welfare reform program (CalWORKs) has provided funding for mental health services needed to assist in employment.

The Center for Mental Health Services contracted for a study of the prevalence of mental disorders among adults. The results of this study were published in the 1999 *Federal Register* and indicated prevalence rates of serious mental illness (SMI) of 5.4 percent and severe and persistent mental illness (SPMI) of 2.6 percent. Data reported below show both prevalence rates, although the 5.4 percent rate is more consistent with the broader population that county mental health programs serve.

STATE POPULATION TO BE SERVED

The State Department of Finance estimates that by 2008 the population of persons over 18 years of age in California will be 37,810,180. Based on the above rates from the *Federal Register* and this population data, it is estimated that there are 983,065 adults and older adults in the State with SPMI, and 2,041,750 adults and older adults with SMI. California, primarily through contracts

with its 58 counties and two city mental health programs, expects to serve 420,000 adults and older adults in SFY 2007-08. The following table shows the total state population, number of clients, and prevalence by age group for SFY 2005-06 and estimated data for SFY 2007-08:

CALIFORNIA POPULATION ESTIMATES, CLIENTS SERVED AND ESTIMATED PREVALENCE OF PERSONS WITH SMI AND SED

	Total	0-8	9-17	18-64	65+
FISCAL YEAR 2005-06					
State Population	36,854,224	4,601,871	5,018,640	23,188,027	4,045,686
Clients Served	670,550	88,120	168,482	400,645	13,303
Estimated Population with SPMI/SED 7% SED and 2.6% SPMI	1,036,825	N/A	339,511	592,472	104,842
Estimated Population with SMI/SED 11% SED and 5.4% SMI	1,981,785	N/A	533,517	1,230,519	217,749
FISCAL YEAR 2007-08					
State Population	37,810,180	4,720,928	4,976,160	23,938,299	4,174,793
Estimated Clients to be Served	683,000	98,000	165,000	397,000	23,000
Estimated Population with SPMI/SED 7% SED and 2.6% SPMI	1,056,802	N/A	336,781	612,074	107,947
Estimated Population with SMI/SED 11% SED and 5.4% SMI	2,024,655	N/A	529,228	1,271,230	224,197

It is estimated that the number of persons to be served in SFY 2007-08 is expected to increase over the number of persons served in FY 2005-06. While California has experienced some budget deficits in past fiscal years, help has arrived in the form of the Mental Health Service Act (MHSA). Mental health service in California counties has been augmented with the passage of a statewide ballot proposition, which adds funds to the mental health system. The proposition established a 1% tax on personal incomes over a million dollars. These funds are being used to transform the California mental health system. The funds are to be used to deliver new and

innovative services and in particular those that are evidence based. Overall it is expected that the MHSA will increase the mental health system statewide by about 15%.

While the MHSA funds are to be used for new services, the system to report these new services has not yet been developed. Due to the long running budget crisis, most counties have deferred procurement of new information systems. Changes required by the DMH due to the Data Infrastructure Grant (DIG) requirements and the MHSA have new pressure to county information systems to make changes. With the MHSA counties have the opportunity to apply to use funds earmarked for Information Technology to transform their reporting systems with a long term vision of developing an Electronic Health Record (EHR) for mental health. In addition, DMH is working with consultants to provide specifications that counties can use when changing their reporting systems that will more easily adapt to an EHR. This situation is complicated by California's 58 counties each of which will be or are in the procurement process for modification of exiting information systems or new systems and software. In many cases this is a long overdue purchase, but it adds uncertainty to the situation. As a result the number of clients served in SFY 2007-08 should increase based on additional service availability, but will depend on how soon counties are able to report. Much depends upon the final decisions county's make on fill their information system needs.

Data from the above table indicates that the rate of treated prevalence for persons with severe and persistent mental disorders was 65 percent, and the rate of treated prevalence for persons with serious mental illness was 34 percent.

There are a number of challenges that DMH faces in order to develop data on unmet mental health needs of the population by ethnicity. The first issue is the development of prevalence data in order to determine need. The Data Infrastructure Grant (DIG) is working on this at a national level. However, the rates that will be provided to states will address the total population. It is known that prevalence is slightly higher in poorer populations, which are the populations of concern to the state mental health program. And, although prevalence rates generally do not vary by race/ethnicity when controlling for socio-economic status, the Hispanic and African American populations tend to be over-represented in the lower socio-economic status. This would tend to increase the prevalence rates for these populations.

STATE-LEVEL REFINEMENTS OF PREVALENCE RATES AND SMI/SED DEFINITIONS

With the implementation of the MHSA there is increased pressure for California to refine the national prevalence rates. Counties have submitted a Community Service and Support (CSS) plan which must be data-driven. It is fortunate that over the last year workgroups of county, provider, and client and family stakeholders have been meeting around issues that have emerged as the result of the need to redesign DMH's data system to capture data elements to meet new federal requirements. The Data Infrastructure Grant (DIG) has served to promote the State's refinement of SMI/SED definitions and to develop State and county specific prevalence rates. For several years, California has provided estimates of the SMI/SED population according to the method described above. While useful for the State as a whole, DMH was not able to respond to

requests to provide prevalence rates of race/ethnicity by county. In 2003, DMH contracted with Charles Holzer, Ph.D., and an epidemiologist from the University of Texas Medical Board (UTMB) to develop California specific prevalence rates. Dr. Holzer had done studies for several of the western States using a synthetic estimate model that applied prevalence rates developed from surveys conducted in the 1990's to the 2000 census data. Dr. Holzer used this same model for California and provided prevalence rates by county and selected demographic characteristics. DMH has maintained an ongoing relationship with Dr. Holzer and he is expected to provide California specific data when the new National Co-Morbidity Study-Revised (NCS-R) data is available in late 2006.

The following table shows the California SMI/SED population using the Holzer method and updated with more recent Census data:

COMPARISON OF STATE POPULATION, SMI/SED POPULATION, AND CLIENTS BASED ON HOLZER METHODOLOGY 2000 CENSUS WITH JULY 2004 UPDATE

	Total	Youth	Adult	18-64	65+
Census		**TOTAL POPULATION - 2000**			
Total Population	37,372,444	10,509,172	26,863,254	22,819,942	4,043,330
Household Population	36,524,190	10,455,031	26,863,223	22,218,503	3,879,156
Household Population Below 200% of Poverty	11,525,888	4,125,270	7,400,619	6,347,880	1,029,791
		SMI/SED POPULATION			
Total	2,466,518	788,188	1,665,522	1,483,296	202,165
Household Population	2,301,024	784,127	1,584,930	1,377,547	155,166
Household Population Below 200% of Poverty	1,017,054	367,496	649,558	587,843	61,715
		PERCENT SMI/SED POPULATION			
Total	6.6%	7.5%	6.2%	6.5%	5.0%
Household Population	6.3%	7.5%	5.9%	6.2%	4.0%
Household Population Below 200% of Poverty	8.8%	8.9%	8.8%	9.2%	6.0%
		CLIENTS SERVED FY 2002-03			
Clients	659,704	203,499	456,205	435,609	20,593

SMI/SED is the estimated number of adults who have a serious mental illness or youth who have a serious emotional disturbance.

The above table shows the population and estimated prevalence for the total population, the household population, and the household population below 200 percent of the poverty level.

DMH's Statewide Quality Improvement Committee has adopted the policy to focus on the population below 200 percent of the poverty level to be used in determining penetration rates. However, there are some limitations in using that population because it includes persons in households only. Many of the persons served by county mental health programs reside in board and care facilities, or residential programs that are not included as households.

Another critical aspect of using the prevalence data to calculate penetration rate is the fact that the prevalence rates focus on the SMI/SED population. While the DMH uses diagnosis only to estimate the number of persons who are SMI/SED, it is not satisfied with using diagnosis as the single factor for determining SMI/SED. Both diagnosis and level of functioning are usually considered when determining if a person is SMI/SED. However, the reporting of functioning level has been incomplete. The DIG utilized workgroup process to address, among other things, the quality of reporting and the data elements it is using to estimate the SMI/SED client population. The DIG recommendations resulted in changes to the DMH's Client and Service Information (CSI) system which are being implemented beginning July 2006. DMH has changed to a DSM IV TR five axis diagnosis. Since this includes functioning level it is expected that this will give DMH a more accurate estimate of the number of clients who are SMI/SED.

The data provided by Dr. Holzer is based on the 2000 census, and the client population shown in the table above is for FY 2003-04. Updates have not been done for more current years because the household population below 200 percent of poverty is not a sub-group of the population that is updated annually. This is only collected on a sample basis at the time of the Census, which is every ten years. The population at lower income levels is growing at a higher rate than average, so the DMH is exploring alternative data sources or methodologies that could be used to update the prevalence data for persons below 200 percent of the poverty level annually.

The DMH believes that the estimates provided by Dr. Holzer showing prevalence rates by demographic characteristics and county are an improvement over using national rates. However, more work needs to be done to update the data, to include parts of the non-household population that would receive mental health services from county mental health, and to refine the data elements that are used to estimate the number of clients who are SMI/SED.

State-Level Performance Indicator Description

In May of 2004 prior to the passage of the Mental Health Service Act (MHSA), the Department presented county level prevalence data to all California counties. Since that time the data has been used extensively by counties as they develop their Service Plans for how they will use their MHSA funds.

In the Departments' continuing efforts to aid counties to refine estimates of their target service population DMH has contracted with the Department of Health Services and the University of California, Los Angeles to add additional questions to the California Health Information Survey

(CHIS). This is an annual survey, which collects data on the health status of Californians. It was included the K-6 in the survey cycle for 2006. The K-6 is a set of questions developed and tested by Ron Kessler, Ph.D. designed to yield a mental health prevalence estimate. This will give us an alternative method to look at prevalence. The sample size is over 50,000, which will allow DMH to use it on a county level and help us to refine our previous prevalence estimates. While the survey is only for persons 18 years and older, we think that it will also allow DMH to have more detail on the ever-growing older adult population. To date DMH has received summarized data, but DMH will receive data sets which will be made available to counties for their on-going MHSA planning process.

In April of 2005 California Department of Mental Health received an administrative supplement from CMHS to analyze and coordinate the addition of the Psychological Health Questionnaire (PHQ-8) to the Centers for Disease Control's (CDC) 2006 Behavior Risk Factors Surveillance Survey (BRFSS) for California. Preliminary data has been made available and will give, when combined with other data, an interesting regional and national perspective. In addition, CMHS has announced that California will receive an additional administrative supplement to add the Kessler 6 (K-6) to the California BRFSS for 2007. This will provide more information for a national perspective on mental health prevalence when combined with the other data on health and health conditions available in the BRFSS data.

Criterion 2: Mental Health System Data Epidemiology

State-Level Performance Indicator Description

Goal:	To be able to more accurately estimate the number of adults and older adults who meet SMI criteria and who are unserved or underserved at the county level.
Objective:	By June 30, 2007, the DMH will analyze the data from the California Health Interview Survey (CHIS) and compare with other mental health prevalence data to inform and improve understanding of Severe Mental Illness (SMI) in California.
Population:	Adults and Older Adults with SMI
Criterion:	Mental Health System Data Epidemiology
Brief name:	CHIS, NCS-R
Indicator:	CHIS data received from with UCLA for analysis.
Measure:	CHIS data received from with UCLA for analysis.
Source(s) of Information:	California Health Interview Survey, National Co-Morbidity Study-Revised
Special Issues:	
Significance:	Allow a comparison with prevalence rates from California's largest health survey.

Fiscal Year: 2007

Population: **Adults and Older Adults with SMI**

Criterion: Mental Health System Data Epidemiology

(1) Performance Indicator:

1: CHIS

(2) FY 2005 .
Actual Not applicable

(3) FY 2006
Project Not applicable

(4) FY 2007
Objective By June 30, 2007, the DMH will analyze the data from the California Health Interview Survey (CHIS) and compare with other mental health prevalence data to inform and improve understanding of Severe Mental Illness (SMI) in California.

(5) % Attain

Criterion 2: Mental Health System Data Epidemiology

Name of CMHS Core Performance Indicator: 1. Increased Access to Services

Population: Adults and Older Adults with SMI

California mental health system's goal is always to increase access to services; however, the funding sources for mental health services have not been stable in recent years. Funds for mental health services have not kept pace with population growth forcing counties to reduce services to all clients and focus on serving only the most seriously ill.

By imposing a 1% tax on taxpayer income in excess of $1 million, the Mental Health Services Act increases funds available for mental health care for new, innovative and transformational services and supports for the previously unserved or underserved persons with mental illness. The determination of how funds are used at the local county level is based on stakeholder input and the individual needs of local communities; however, MHSA dollars typically cannot be used to supplant or replenish simultaneous fund losses in existing programs; therefore targeted increases in persons served remain conservative. County community services and supports began in January 2006 and target unserved and underserved SMI/SED adults, older adults, children/youth and transition-age youth.

DMH estimated an increase of 10,000 to 15,000 unserved and underserved SED/SMI clients served over the first three years of MHSA implementation (an average of 4,166 or 0.79% per year). The increase in the number of adults and older adults with SMI served for SFY 2005-06 was 6,753. This represented an estimated 1.9% increase in the number served from the previous SFY indicating that we exceeded our target by approximately 1.2%.

Fiscal Year	2004-05 Estimated Actual*	2005-06 Estimated Actual*	2006-07 Target
Performance Indicator For Adults and Older adults with SMI/SED	355,369	362,122	362,122
Increase		6,753	0

Because MHSA is in the initial stages of implementation, and increases in numbers of consumers served is variable across counties, we do not wish to overestimate expected increases based on initial increases for SFY 2006-07. Therefore, we expect to hold the SFY 2005-06 number served steady for the upcoming year.

CRITERION 4. TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS

A. The plan provides for the establishment and implementation of a program of outreach to, and services for, such individuals who are homeless.

B. The plan describes the manner in which mental health services will be provided to individuals residing in rural areas.

INTEGRATED SERVICES FOR HOMELESS ADULTS WITH SERIOUS MENTAL ILLNESS

Recent estimates indicate that there are approximately 50,000 people who are homeless, have a serious mental illness, and are living on the streets of California. Of that number, approximately 20,000 are thought to be veterans. New programs that differ markedly from traditional mental health services have been developed to address the need of this population. Then Governor Davis signed AB 34 (Chapter 617, Statutes of 1999) and approved $10 million to authorize pilot programs in three counties (Los Angeles, Sacramento and Stanislaus) for demonstration grants to provide comprehensive services for adults with mental illness who are either homeless, at risk of homelessness, or at risk of incarceration.

Based on the success of these pilot programs, evidenced by positive client and system outcomes, the Governor provided $55.6 million in the state budget for Fiscal year 2000-2001 to expand services for Adult System of Care Programs directed particularly at serving homeless persons, parolees, and probationers with serious mental illness. This funding, which provided for the expansion from three AB 34 pilot programs to a total of thirty-four AB 34/2034/334 programs statewide, has continued to be provided through Fiscal Year 2005-06, and is proposed for continuation in Fiscal Year 2006-07.

AB 34/2034/334 programs provide client-driven integrated, comprehensive services that support persons moving from homelessness to living independently, working, maintaining community supports, caring for their children, remaining healthy, and avoiding crime. The services provided in this program include but may not be limited to outreach, supported housing (including immediate, transitional and permanent), supported employment, mental health and medical treatment along with related medications, substance abuse, benefits assistance, and other non-medical services necessary to stabilize this population. The programs establish close collaboration at the local level among core service providers, including mental health, law enforcement, veterans' services agencies, and other community agencies. They also establish collaborative relationships and supports with other community partners including landlords and employers.

One outcome goal for AB 2034 programs was to decrease homelessness, acute hospitalizations, and incarcerations of persons with severe mental illness. As of January 31, 2006, there were 4,622 homeless persons with serious mental illness enrolled in AB 2034 programs. Based on cumulative information starting with the establishment of these programs in 1999, the number of days of psychiatric hospitalization, incarceration and homelessness experienced by persons in

these programs have dropped significantly. Specifically days of hospitalization have dropped 65.4 %, days of incarceration have dropped 76.6 %, and the number of days spent homeless dropped 72.9 %. Another important outcome goal for this program was to increase the number of days persons were employed. This year, the number of days of full-time employment since enrollment increased 52% while the number of days of part-time employment rose dramatically reflecting a 201.7% increase since program enrollment. The number of unduplicated adult consumers who engaged in educational activity from pre-enrollment to post-enrollment increased 74.48 percent.

The passage of the Mental Health Services Act (Proposition 63) in November 2004, has been hailed as a validation of the success of AB 2034 programs. Many provisions of the Act related to adult services were based on the values, design, service model and evaluation methodology established for AB 2034 programs. As such they were promoted as a new way in which mental heath services could be offered and mental health programs held accountable for their results. The Department has designed statewide application and review processes to ensure that the principles of recovery, wellness and resilience promoted in AB 2034 programs are implemented in programs funded through the MHSA. Additionally, discussions about the statewide, client-specific, outcome measurement system developed for the MHSA indicate that AB 2034 outcome measurement methodologies have been embraced by the Department as a framework for ensuring ongoing accountability under the Act. As expected the Department will require county programs to adopt an objective quality of life outcome reporting system similar to the type that has been so successful in documenting the outcomes of AB 2034 program participants.

PERSONS WHO ARE HOMELESS AND HAVE A MENTAL ILLNESS

The DMH has been awarded federal homeless funds annually since 1985, initially through the Stewart B. McKinney Homeless Block Grant, and beginning in SFY 1991-92, through the McKinney Projects for Assistance in Transition from Homelessness (PATH) formula grant. The PATH grant funds community based outreach, mental health and substance abuse referral/treatment, case management and other support services, as well as a limited set of housing services for the homeless mentally ill. During SFY 2005-06, a total of 37 counties elected to participate in the PATH program. While local programs serve thousands of homeless persons with realignment funds and other local revenues, the PATH grant augments these programs by providing services to approximately 15,000 additional persons annually. Each county determines the use of PATH funds based on local priorities and needs. These targeted funds provide much needed services to an extremely vulnerable population throughout California.

In accordance with federal procedures, the DMH's PATH and housing staff have developed guidelines that define the counties' responsibilities to clients who are homeless and have a mental illness. Counties receiving PATH funds must annually develop a service plan and budget for utilization of the funds. The service plan must describe each program setting and the services and activities to be provided. The estimated number of persons to be served must also be included in the plan. Each county that receives PATH funds has established one or more programs of outreach to, and/or services for, persons who are homeless and have a mental illness.

Allowable PATH services include:

- Primary Service Referrals
- Habilitation and Rehabilitation
- Alcohol/Drug Treatment
- Service Coordination
- Screening and Diagnostic Treatment
- Outreach
  - Community Mental Health
  - Staff Training
- Housing Services
- Supportive Services in Residential Settings

In addition to demographic information, the PATH-funded programs also report outcomes relative to achievement of their objectives. The most fundamental goal for PATH programs is outreach and engagement to persons who would otherwise not receive services due to the combined conditions of homelessness and serious mental illness. In SFY 2004-05 (most recent available data), 16,952 individuals in California received some combination of PATH supportive services.

In an effort to improve and expand services to the homeless mentally ill, PATH staff participate in federal, State, and local groups involved in developing effective public policy related to the problem of homelessness. Other PATH staff responsibilities include providing information and education on the needs of persons who are homeless and have a mental illness, and serving as liaisons to State and local organizations.

The SFY 2005-06 PATH allocation to California was $7,509,000. Of this amount, $7,382,000 was distributed among 37 counties to continue regular PATH programs. The balance of $127,000 was utilized for PATH administrative costs.

The DMH has been notified that in SFY 2006-07 the federal PATH allocation to California will be reduced by $84,000, thus bringing the total to $7,425,000. This funding will be used to continue the standard PATH program in participating counties, contingent upon the budget process.

MENTAL HEALTH SERVICES FOR ADULTS RESIDING IN RURAL AREAS

Definition of "Rural Area"

While California is generally perceived nationally as an urban State, a significant proportion of the State is considered rural. Rather than rely upon the more general definitions of "rural" and "urban" utilized in the compilation of U.S. Census Bureau statistics, California health planning agencies have adopted a definition promulgated by the California Rural Health Policy Council (RHPC). The RHPC is the official California agency charged by the State Legislature with oversight of rural health care matters.

The Council defines rural areas as follows: "Rural areas are Medical Service Study Areas as defined by the Office of Statewide Health Planning and Development (OSHPD) that have a population density of less than 250 persons per square mile and have no incorporated community

with a population greater than 50,000 people." The provision of publicly funded rural health care services, including those for mental health treatment for adults and older adults, are predicated upon this definition.

Mental Health Services for Adults and Older Adults

In providing mental health services to adults, California draws a distinction between the adult population age 18 to 64, and the population of adults age 65 and older. Specifically, California recognizes that individuals under age 65 often have different mental health treatment needs than those who have reached retirement age.

This need becomes even greater with age. In November of 2004, California passed Proposition 63, which became the Mental Health Services Act (MHSA). The Act indicates, "Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government." Additionally, the Act finds that "adults lose their ability to work and be independent, many become homeless, and are subject to frequent hospitalizations or jail."

The rural elderly encounter many of the same challenges as their urban counterparts in gaining access to services and maintaining their independence. These challenges are much more difficult to overcome because of the demographic and socio-economic challenges inherent in this population.

In general, the mental health treatment needs of adults living in rural counties, appear to be similar to the needs of adults in urban areas. However, these needs, as well as the more unique needs of older adults, often go either untreated or under-treated due to barriers that are unique to rural areas.

Significant Barriers To Treatment In Rural Areas

The primary barriers identified by DMH include the following:

- **Transportation Problems**

  Limited or no access to public or private transportation makes mental health treatment access virtually impossible for many rural residents. Severe geographic barriers, such as mountainous terrain or vast distances from available services, exacerbate this problem. Medical transportation services are excluded from Medi-Cal reimbursement, except in instances of transporting the beneficiary from a psychiatric inpatient hospital to another 24-hour care facility. Consequently, this creates yet another systemic barrier.

  According to the report, "Best Practices in Service Delivery to the Rural Elderly," 40% of rural residents live in areas with no public transportation system, 80% of rural counties have no public bus service, and, although the automobile is their only mode of transportation, 57% of rural residents do not own a car.

- **Lack of Qualified Mental Health Professionals**

  In the February 2003, the California Workforce Initiative released its' report, "The Mental Health Workforce: Who's Meeting California's Needs?" The report finds that nearly 30% of licensed mental health personnel are employed in the 10-county Bay Area and 24% are employed in Los Angeles County. Interestingly, those employed in the Central Valley and North County regions of the state jointly comprise only 9% of the total workforce.

  California's rural mental health care suffers from severe staff and specialist shortages that limit access for many residents. The Workforce Initiative's general workforce data shows that the demand for mental health professions will grow significantly over the next decade. From 2001 to 2010, their forecast indicates an overall demand for mental and behavioral health care workers with an expected growth from 63,000 to between 73,000 and 80,000 (between 16-30%).

  Additionally, the California Legislative Analyst's Office (LAO) released a report entitled, "HMO's and Rural California" in August 2002. Their analysis indicates that HMOs are withdrawing coverage from rural California because a combination of circumstances makes it difficult for them to profitably operate. The LAO found that circumstances included: a residential population that is relatively expensive to insure; the inherent difficulty of distributing the risks and costs of health coverage to a smaller population base; shortages of health care providers; expensive medical practices that increase costs; and concerns over reimbursement rates for care paid by health-care purchasers. As of May 2002, 37% (11) of rural/small counties no longer have HMOs providing services on a countywide basis. Statistics indicate that since 1997, declining enrollment has affected an estimated 5 million residents. Two California counties experienced a 78% drop and 95% drop in enrollment in that same time period. This trend continues to increase, indicating an increasing lack of mental health services that will heavily strain county mental health resources and that are approaching critical levels. If HMO's provided an incentive for qualified staff to work in these areas, the counties might be more successful with staff retention.

  Even more acutely felt within the rural mental health treatment community, is the lack of culturally competent staff with special expertise in non-English languages, cultural differences, and age and gender issues. During the Community Program Planning component of the MHSA in Spring 2005, local mental health departments were asked to access their counties' underserved and unserved communities, including the reduction/elimination of racial and ethnic disparities. Furthermore, DMH requested that counties provide county-specific information on staffing/provider data including gender and race/ethnicity.

- **Few Available Psychiatric Hospital Beds**

  The lack of available hospital beds and related resources (e.g., skilled nursing/sub-acute) is problematic even in the primary health care field for California's rural areas. It is an especially drastic situation with respect to available sites for providing acute and sub-acute psychiatric treatment in most rural areas. Given the nature of mental illness, and the likelihood of the need for crisis intervention during the course of mental health treatment for many clients, this particular resource deficit is highly significant.

In June 2004, the Shasta County psychiatric health facility (PHF) closed its doors due to budget constraints. This has been a serious hardship for many of the rural counties in Northern California since the Shasta PHF was a hub for the region.

Current Efforts At Mitigating These Barriers

- **Working Groups**

  There are a number of working groups that concertedly seek solutions to the above barriers in rural areas, most notably the Small County Directors and Superior Region Committees of the CMHDA. This Committee held its biannual retreats in August 2004 and May 2005 to address various barriers. CIMH has more than one committee functioning under its guidance with specific focuses on rural mental health treatment concerns and issues. Finally, the RHPC identifies and plans for approaches to rural-based impediments to effective mental health services delivery. DMH participated in the RHPC public hearing in February 2005.

- **Technology**

  Telemedicine technology is a prime opportunity to explore the efficacy of collaborations between the mental health and physical health services systems. County mental health departments have always relied on collaborative efforts to avoid duplication and maximize cost effectiveness. This especially is true in rural areas, which have traditionally shared a small number of providers and hospitals. The establishment of telemedicine services is no exception.

  One of these telemedicine networks is the Northern Sierra Rural Health Network (NSRHN), which provides services to 9 Northern Region counties. These counties are Modoc, Siskiyou, Shasta, Lassen, Plumas, Sierra, Nevada, and Trinity. NSRHN serves health care professionals, organizations, and agencies covering more than 27,000 square miles of Northeastern California.

  Additionally, the UC Davis Center for Health and Technology (CHT) is home to a highly successful telemedicine program offering over 30 specialty consultations. Telepsychiatry has been a part of this program since 1996. To date, just over 1,200 telepsychiatry consultations have been conducted. By augmenting the existing telemental health care service, the collaborative efforts of the UCD Department of Psychiatry and Behavioral Sciences and the CHT enhances the delivery and access to telemental health care services to these rural communities by an interdisciplinary team.

- **Addressing California's Staffing Shortages**

  Part of the intent of the MHSA is to establish a program to remedy the shortage of qualified individuals to provide services to address severe mental illnesses. In 2006, each county mental health program is required to submit a needs assessment identifying its shortages in each professional and other occupational category. The purpose of the assessment is to

increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide increased services to additional individuals and families. DMH will identify the total statewide needs for each professional and other occupational category and develop a five-year education and training development plan.

- **Increasing Available Beds**

  The Superior Region and Small Counties Directors of CMHDA have been working with a local provider to open two new 16-bed psychiatric health facilities in Yuba City. After a few years of planning, the North Valley Behavioral Health facility is expected to open on August 15, 2005. The opening date for the second facility, Sequoia Psychiatric, is undetermined at this time. Once both facilities are open, 32 new beds will be available.

Criterion 4: Targeted Services to Rural and Homeless Populations

State-Level Performance Indicator Description

Goal:	Expand services to adults and older adults with SMI in rural counties.
Objective:	By June 30, 2007, update data on community-based outpatient services to adults and older adults with SMI in rural counties and include race/ethnicity in the analysis.
Population:	Adults and older adults with SMI who live in rural counties.
Criterion:	Targeted Services to Rural and Homeless Populations
Brief name:	Rural Services
Indicator:	Number of adult and older adult clients with SMI receiving outpatient services and units of outpatient service provided to that population by race/ethnicity.
Measure:	Number of adult and older adult clients with SMI receiving outpatient services and units of outpatient service provided to that population.
Source(s) of Information:	Client and Service Information Data System
Special Issues:	
Significance:	

Fiscal Year: 2007

Population: Adults and Older Adults with SMI

Criterion: Targeted Services to Rural and Homeless Populations

(1) Performance Indicator:

1: Rural Services

(2) FY 2005
Actual Not applicable

(3) FY 2006
Project Not applicable

(4) FY 2007
Objective By June 30, 2007, update data on community-based outpatient services to adults and older adults with SMI in rural counties and include race/ethnicity in the analysis.

(5) % Attain

CRITERION 5. MANAGEMENT SYSTEMS

- **The plan describes the financial resources and staffing necessary to implement the requirements of such plan, including programs to train individuals as providers of mental health services, and the plan emphasizes training of providers of emergency health services regarding mental health.**

- **The plan contains a description of the manner in which the State intends to expend the grant for FY 2007 to carry out the provisions of the plan.**

COMMUNITY RESOURCES FOR
ADULT PROGRAMS
STATE FISCAL YEAR 2006-2007

DMH - Local Assistance	$ 63,180,000
DMH - Managed Care	173,232,000
DMH - CMHS Block Grant	37,154,000
DMH - PATH	7,382,000
DMH - Brain Impaired Adults	11,747,000
DMH - Short-Doyle/Medi-Cal Match	462,198,000
Total DMH	**$754,893,000**
Realignment Funds	1,010,334,000
Total Community Programs	**$1,765,227,000**

Note: The information included for Short-Doyle/Medi-Cal Match does not reflect the Federal Financial Participation (FFP) for Managed Care Inpatient Services.

HUMAN RESOURCES DEVELOPMENT

There is a current crisis in the number of mental health professionals trained and able to provide appropriate services to the most severely disabled public mental health clients, with projections for significant increased needs as we move into the 21st century. These acute shortages include staff serving clients who are bilingual/bicultural and those who live in both inner cities and in rural areas. There are also critical shortages of child psychiatrists as well as professionals trained to serve the elderly and other special populations. In addition, California's state hospitals are experiencing acute shortages of psychiatric technicians, nurses, and other clinical staff.

The DMH, in collaboration with the Administration, CMHDA, CMHPC, and other concerned stakeholders, will be addressing the current and future staffing needs in the coming fiscal year. The CMHPC has identified the shortage of human resources at all levels as one of the most urgent issues facing the mental health system. In an effort to address the crisis facing the mental health system, the CMHPC convened the Human Resources Summit 2000. Through a collaborative process, key decision-makers determined nine major aspects of the staffing shortage including: expanding the capacity of postsecondary education; work readiness in the classroom; multi-lingual and multicultural pipeline strategies; school-to-career strategies; job retraining for mental health occupations in the public sector; direct consumer and family member employment; licensing boards and professional recruitment; rural strategies; and community redefinition, corporate partnerships, and collaboration.

The Human Resource Project was developed to implement the action plan resulting from the March 2000 summit. The overall mission of the Human Resource Project is to increase the mental health workforce and to increase its cultural competence and diversity. Diversity is defined very broadly to include ethnicity, language, gender, age, and clients and family members. As of June 30, 2006, the Human Resource Project has accomplished the following:

- Conducted a professional symposium with secondary education partners, and other stakeholders to develop strategies to increase mental health career opportunities in secondary educational programs.

- Convened a series of informational meetings and roundtable discussions with consumer and family member employment training programs to document strategies to engage and include consumers and family members from diverse ethnic communities in training programs.

- Produced a Developing a Curriculum (DACUM) for marriage and family therapists working with California's public mental health system. A DACUM is a nationally recognized, standardized approach to job analysis that produces a complete job profile including prioritized tasks. The DACUM has established a foundation for developing or enhancing current curricula offered in marriage and family therapy education programs that is relevant to practice in California's public mental health system.

- Developed a DACUM project for psychiatric technicians. The DACUM project will compare the results of the community-based agency DACUM with those from a DACUM conducted with psychiatric technicians from state hospitals. The goal is to determine if current certificated programs in the State are providing the depth and breadth necessary for the current level of practice required in California's public mental health system.

- Developed an Integrated Dual Diagnosis DACUM (IDD-DACUM). A significant proportion of clients in the public mental health system have co-occurring, mental health and substance abuse issues. However, there is a dramatic shortage of mental health workers qualified to provide integrated mental health services. The developed DACUM produced the information necessary to begin the process of producing a curriculum for training staff to address this shortage.

- Published a Psychiatric/Mental Health Nurse Practitioner brochure targeted to various levels of the career ladder. The brochure will assist in an effort to recruit individuals into the profession and promote the increased utilization of psychiatric mental health nurses in California's public mental health system.

- Published a guide entitled "A Guide for Developing Mental Health Components in High School Academies." This guide encourages the development of local partnerships among local mental health employers and education programs that will result in the establishment of mental health components in high school health academies and other education programs. This partnership should stimulate a workforce pipeline that attracts youth, especially from ethnically diverse backgrounds, into pursuing mental health careers.

- Produced a report entitled, "Consumer and Family Member Employment in the Public Mental Health System." The Human Resources Project Consumer and Family Member Task Force developed the report to promote the employment of consumers and family members in the mental health system. The study determined that approximately 1,600 consumers and family members were employed in 36 counties in both full- and part-time positions. It identified both successful model programs for replication and barriers that need to be overcome to increase employment opportunities.

- Collaborated with Assembly Member Leland Yee's Office to develop Assembly Concurrent Resolution 54, a measure that proclaims the 3rd week of May of every year as Mental Health Occupations Week. The resolution encourages mental health professionals, persons with mental illness, family members, schools, academic institutions, and policymakers to work together to promote mental health occupations.

- Completed the initial phase of a retired persons project that placed retirees in job/career roles in the California public mental health system.

- Collaborated with Assembly Member Leland Yee's Office to develop AB 938, a bill that extends a loan repayment program administered by the Office of Statewide Health Planning and Development to mental health professionals. This bill will assist students in managing the expenses of going to school in exchange for the commitment that, upon graduation, individuals will serve in eligible county facilities or health manpower shortage areas that are culturally and linguistically diverse.

- Convened a series of focus groups with multicultural social workers from various agencies, including mental health, social services, and alcohol and drug, to determine how to make mental health occupations and academic programs more attractive to bilingual and bicultural students, and produced a summary report of recommendations for schools of social work and the mental health system.

- Advocated for federal legislative staff to support current federal funding efforts to assist individuals who choose mental health occupational and educational pathways.

- Collected data on vacancy rates among 22 occupations working within the public mental health system.

- Researched the capacity of the educational system to train professionals and paraprofessionals for work within the public mental health system.

- On behalf of the DMH, staffed the SB 1748 Task Force and prepared a report to the State Legislature.

- Convened a workgroup to address the shortage of nursing professionals and expand the utilization of psychiatric nurse practitioners in California. As an outcome of this workgroup, the CMHPC published a manual entitled "Expanding the Use of Psychiatric Nurse Practitioners in Behavioral Health Settings: Resource Materials."

The Human Resource Project intends to produce at least the following products and advance the following activities in the coming fiscal year:

- Convene a consumer and family member workgroup to make recommendations to the CMHPC and the DMH on consumer and family member employment programs and opportunities that are consistent with the recommended activities of the Mental Health Services Act Education and Training Program components.
- Provide technical assistance to local mental health departments on how to engage secondary educational programs as part of a long-term workforce development strategy.
- Establish a postsecondary educational workgroup to provide the CMHPC and DMH with information on how to develop a "core-curriculum" that can be used in postsecondary educational programs to assure the production of a cultural proficient "work-ready" workforce from educational programs. In addition, the group will advise the DMH on how to develop requirements related to the provision of loan repayment programs that will hold educational programs accountable for increasing student diversity and cultural competency.
- Facilitate the development of a DACUM for Transition Age Youth. The MHSA provides a unique opportunity to expand services to youth who are connected to a variety of service systems throughout California's Social Welfare system. The goal of this DACUM is to utilize an expert pool of youth to oversee a job development analysis of professionals they have identified. The DACUM will communicate to professionals and organization the skills and abilities that are necessary for individuals who are providing services to youth.
- Develop A DACUM for Child and Adolescent Psychiatry. The DACUM will establish a foundation from which to enhance the focus of residency programs by determining the current job environment, skills, and functions that child and adolescent psychiatrists are providing in the public mental health system. The DACUM will facilitate the implementation of clear educational pipeline strategies to attract individuals into the field, as well as, enhancing curricula.
- Develop a DACUM for Telemedicine. This DACUM will set a foundation for understanding and advancing the skills and abilities of those practicing telepsychiatry and set a foundation for

additional work in developing a core curricula to be utilized by individuals who are mental health professionals to provide culturally competent services via technology.

- Develop a DACUM for Peer Support Specialists. The DACUM will allow for a standardized review of what current peer support professionals are doing in the public mental health system. In addition, the DACUM will enable employers to determine the training that will best enhance the work of peer support, allowing organizations to develop career ladders that link to other professions for consumers who work in these positions.

- Facilitate a time-limited Recovery Standards Task Force. The charge of the taskforce will be to develop standards and core-competencies that can be utilized by providers and community-trainers to create a consistent understanding of wellness, recovery, and resiliency. In addition, those evaluating Community Services and Supports plans and education and training proposals required by the Mental Health Services Act will have a standard operationalized set of components to document.

- Establish a time-limited workgroup to focus on the unique needs of older adults within the public mental health system. The goal of the workgroup will be to assist in the design of a statewide Summit, highlighting the current understanding of service needs for individuals age 55 to 59, and those older adults who are 60 years and older. The Summit will have an emphasis on the occupational needs that will be required to meet the needs of this special population and will serve as a first-step by the CMHPC in exploring both the service and occupational needs of special populations in the public mental health system.

- Continue to promote the recruitment of retirees in California's public mental health system. Developing strategies to recruit retirees will assist county mental health departments and community-based agencies in being able to have an adequate workforce to provide services.

- Expand post-secondary educational opportunities for mental health occupations through encouraging distance education career ladder programs and promoting secondary and post-secondary educational programmatic coordination.

- Provide technical assistance to regional and statewide organizations that are currently developing workforce and educational recruitment and retention plans.

In addition, under the Mental Health Services Act (MHSA), the DMH must collect county data, complete a statewide occupational needs assessment, and develop a five-year plan addressing a statewide mental health education and training program. In meeting this legal obligation, DMH is committed to increasing the quantity and quality of trained persons available for employment in the mental health system while increasing family and consumer involvement in service delivery and encouraging development of a diverse workforce. The MHSA envisions a system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children and youth with serious emotional disorders and their families. In addition, mental health services should be effective in helping adults, children and families reach their goals through the development of individualized service plans and delivery of evidence-based practices. The MHSA education and training component offers an opportunity to transform the system to reflect these values. Accordingly, DMH decision-making will include principles that promote and support education and training efforts that reflect client recovery/wellness and resiliency. The Department is fully vetted and actively involved in a public stakeholders process to solicit input on ideas for effective use of MHSA

Education and Training funds. No decisions regarding implementation of plans for Education and Training funding will be made until all stakeholder input is considered.

DEPARTMENT OF MENTAL HEALTH TRAINING

The DMH State Hospitals' Training Officers provide a wide range of training opportunities for State Hospital employees. The Headquarters Training Officer reviews, approves and tracks headquarters employee training requests. The Headquarters Training Office also acts as liaison with State Hospital Training Officers regarding issues that impact all DMH employees.

Current staff development efforts are focused on:

- The State Hospitals conducting annual training needs assessments;
- The State Hospitals implementing an annual training plan; and
- The State Hospitals evaluating the success of the plan at the conclusion of the fiscal year.

Training currently offered by the DMH State Hospitals and the Headquarters Training Office includes, but is not limited to, the following:

- Training required by the Government Code, Department of Personnel Administration policy, DMH policy, agreements between the State of California and employee union organizations, and, at the State Hospitals, the Joint Commission on Accreditation of Healthcare Organizations.
- Training using the DMH computer network, which links DMH headquarters, the State Hospitals, and field offices.
- PsychLINK professional clinical training sessions presented via DMH satellite. Continuing Education Credits are offered and other departments are invited to attend. The Hospital Training Offices are responsible for registering, grading and faxing test results for staff to receive continuing education credits to maintain their licensure. Topics include "Compliance with Antidepressant Therapy" and "Beyond Efficacy: Obesity and the Psychotic Patient." These sessions are also videotaped and can be viewed at later dates.
- State Hospitals presenting training programs with DMH staff and participants from county mental health programs on such topics as dual diagnosis, biopsychosocial treatment planning, and vocational rehabilitation programming.

The DMH Information Technology unit coordinates with the data center, outside vendors, and headquarters based computer training for DMH employees. Computer training provided by outside vendors includes Microsoft Windows 2000, Word, Excel, PowerPoint, Visio, and other appropriate courses. The Health and Human Services Data Center (HHSDC) offers one-to-three day courses in standard PC applications as well as longer and more specialized subjects. The Information Technology unit also provides consultation to DMH staff in selecting the most appropriate computer training classes.

The CMHPC, in partnership with CMHDA, CIMH and the California Association of Local Mental Health Boards, is continuing development of a statewide training plan for mental health professionals, direct consumers and families to communicate the emphasis on client-directed services.

The DMH has contracted in the past, and will continue to contract with external providers and State organizations such as the CPS Human Resource Services, Health and Human Services Data Center, universities and community colleges for training. The scope of training topics includes managed care, dual diagnosis, children's SOC, performance outcomes, and independent living with a focus on employment.

The DMH has developed the capability for interactive videoconferences that links headquarters and all State Hospitals. In addition, some counties, other government agencies, and State universities have the same capability so the system can be used with local mental health programs as well. Teleconferences are presented to promote more efficient communication while saving travel costs and time. The videoconference unit also has a document camera and videocassette recorder so documents can be read simultaneously in several locations and conferences can be recorded. For the same cost savings reasons, DMH has installed a satellite dish at headquarters that allows the onsite down linking of important professional development programming from throughout the United States.

The DMH, the CMHDA, the CMHPC, and the California Association of Local Mental Health Boards want to stress the need for continued and expanded federal funding of Human Resources Development programs. These funds are essential to State and local efforts to train the State's mental health work force, especially in light of the unique multicultural and linguistic needs of California.

COMMUNITY AND EMERGENCY HEALTH SERVICES PROVIDER EDUCATION

DMH community and emergency health services provider education efforts include distribution of educational materials produced by NAMI California through a contract with DMH. In addition to a broad array of educational materials in print and electronic-media format on a wide range of mental health subjects, NAMI California has produced a number of videotapes designed to educate the public, particularly law enforcement and emergency health services providers, on the nature of mental illness and dealing with individuals in crisis. Additionally, NAMI California has developed a series of booklets that have been most helpful to families of newly diagnosed persons.

In SFY 2001-02, NAMI California designed and implemented a website that provides education and support to family members and consumers. The website provides family members and consumers with current information on serious mental illness 24 hours a day, 7 days a week. The website address is www.namicalifornia.org. In SFY 2004-05, NAMI California improved functionality of the site and expanded the number of languages supported by adding translations for Korean and Tagalog to Spanish and Chinese translations. NAMI California continues to update and maintain the website on a daily basis including contacting, verifying and updating over 3500current and new service providers that treat serious mental illness; maintaining and updating listings of local affiliates and organizations that assist families and consumers; maintaining, updating and facilitating Family-to-Family class schedules and registrations, researching, selecting, preparing and posting news stories relating to mental illness and mental health, including stories regarding government polices and programs, advances in treatment and pharmaceutical company announcements regarding new drugs, side effects and research. It is anticipated that DMH will continue to fund this effort in SFY 2005-06.

DMH supported the efforts of the Mental Health Association in California to update and print in both English and Spanish more copies of its brochure "*Reaching for the Light*," a resource guide for coping with mental health problems. The guide, designed to give information to mental health and emergency health services providers and the general public, provides information on all aspects of mental health

and mental illness, including such topics as finding help for yourself, children, adolescents, adults and older adults; how therapy works; paying for mental health care; mental disorders; and choosing a mental health professional. DMH makes this guide available to providers and the general public upon request.

DMH Disaster Assistance Coordinator (DAC) maintains a liaison role with the California Department of Health Services and Emergency Medical Services Authority for emergency planning and assistance. As part of an inter-disciplinary training team, the DAC participates in an annual training course entitled "Disaster Bootcamp," which is offered to emergency medical and health services personnel. This presentation includes an overview of the mental health issues relevant to natural disasters and terrorist events and responder coping and stress management. The DAC is a licensed mental health clinician qualified to teach courses on mental health issues that emergency health services providers may experience in the course of their work.

EXPENDITURE PLAN FOR FISCAL YEAR 2007

The DMH will allocate the FY 2007 Community Mental Health Services Block Grant to local county mental health departments in State Fiscal Year (SFY) 2007-08. These funds will be used to promote the implementation of integrated systems of care and to fulfill the mission of the California mental health system. In addition, the DMH will allocate a portion of the block grant to support the CMHPC.

The DMH, as the State's designated recipient of the Block Grant, allocates the funds to counties either based on a legislated formula or on a competitive basis. The base allocation provides a stable, flexible and non-categorical funding base, which the counties can use to develop innovative programs or augment existing programs within their systems of care for adults with SMI or children with SED. In order to receive the base allocation, each county is required to submit an annual application or expenditure plan that includes a narrative detailing its intended use of the funds.

Block grant funding may also be awarded through a competitive process. The process is structured to encourage counties to adopt proven practices and to promote innovation and risk-taking by encouraging counties to explore new approaches.

The plan for expenditure of FY 2007 Block Grant funds includes:

- $44,679,426 in base allocation monies to 58 counties. This base includes an $8,059,000 set-aside to support existing efforts to provide integrated treatment services for individuals with a dual diagnosis of SMI and a substance abuse disorder;

- $3,987,515 to provide ongoing funding to support seven competitively awarded Children's System of Care programs (see the description of the Children's System of Care programs within this application's narrative);

- $2,000,000 to support two Integrated Services Agencies (ISA's);

- $200,000 to support Human Resource Development (HRD);

- 20,000 to support the efforts of the COJAC

- $3,279,000 for DMH Administrative and Support costs (includes funding for CMHPC).

The plan for expenditure also includes $534,361 to be allocated to counties to fund additional programs within their Adult and/or Children's System of Care.

The following chart summarizes the Department's proposed total SAMHSA Block Grant funds to be allocated for adult and children's mental health services for SFY 2007-08.

SAMHSA/CMHS BLOCK GRANT SFY 2007/08 PROPOSED EXPENDITURES

COUNTY	BASE ALLOC	DDX SET-ASIDE	HRD PROJ.	CHILDREN SOC	ISA FUNDING	CO-OCCURING DISORDERS	EXPENDITURE TOTAL
ALAMEDA	$ 539,193	$ 152,415					$691,608
ALPINE	$ 10,008	$ -					$10,008
AMADOR	$ 31,514	$ 8,477					$39,991
BUTTE	$ 241,046	$ 94,983					$336,029
CALAVERAS	$ 107,770	$ 11,903					$119,673
COLUSA	$ 51,745	$ 1,535					$53,280
CONTRA COSTA	$ 1,502,286	$ 76,984					$1,579,270
DEL NORTE	$ 110,117	$ 13,127					$123,244
EL DORADO	$ 96,628	$ 38,077					$134,705
FRESNO	$ 1,063,068	$ 418,899					$1,481,967
GLENN	$ 107,391	$ 8,700					$116,091
HUMBOLDT	$ 259,412	$ 45,532		$ 183,692			$488,636
IMPERIAL	$ 290,750	$ 64,292					$355,042
INYO	$ 159,328	$ 985					$160,313
KERN	$ 874,497	$ 231,820					$1,106,317
KINGS	$ 121,506	$ 47,879					$169,385
LAKE	$ 166,133	$ 28,454					$194,587
LASSEN	$ 85,725	$ 13,429					$99,154
LOS ANGELES	$ 11,557,984	$ 1,162,873		$ 1,012,034	$ 1,000,000	$ 20,000	$14,752,891
MADERA	$ 162,311	$ 45,596					$207,907
MARIN	$ 250,176	$ 98,581	$ 200,000				$548,757
MARIPOSA	$ 90,603	$ 2,534					$93,137
MENDOCINO	$ 31,462	$ 12,398					$43,860
MERCED	$ 395,715	$ 114,295		$ 351,535			$861,545
MODOC	$ 10,113	$ -					$10,113
MONO	$ 10,016	$ -					$10,016
MONTEREY	$ 402,330	$ 93,279		$ 740,475			$1,236,084
NAPA	$ 175,331	$ 69,089					$244,420
NEVADA	$ 58,112	$ 22,899					$81,011
ORANGE	$ 1,633,979	$ 559,023					$2,193,002
PLACER	$ 195,064	$ 46,365		$ 444,188			$685,617
PLUMAS	$ 209,881	$ 8,136					$218,017
RIVERSIDE	$ 2,072,058	$ 360,159					$2,432,217
SACRAMENTO	$ 1,441,610	$ 498,582					$1,940,192
SAN BENITO	$ 31,085	$ 12,250					$43,335
SAN BERNARDINO	$ 2,495,242	$ 610,357					$3,105,599
SAN DIEGO	$ 2,334,874	$ 878,852					$3,213,726
SAN FRANCISO	$ 1,991,209	$ 685,821					$2,677,030
SAN JOAQUIN	$ 828,294	$ 282,744					$1,111,038
SAN LUIS OBISPO	$ 123,444	$ 57,159		$ 254,061			$434,664
SAN MATEO	$ 681,091	$ 164,338					$845,429
SANTA BARBARA	$ 165,592	$ 33,828					$199,420
SANTA CLARA	$ 532,675	$ 172,184					$704,859
SANTA CRUZ	$ 94,886	$ 22,376					$117,262
SHASTA	$ 190,913	$ 75,228					$266,141
SIERRA	$ 48,653	$ 317					$48,970
SISKIYOU	$ 96,061	$ 22,840					$118,901
SOLANO	$ 117,288	$ 46,217					$163,505
SONOMA	$ 202,545	$ 42,804					$245,349
STANISLAUS	$ 530,536	$ 185,018		$ 1,001,530	$ 1,000,000		$2,717,084
SUTTER/YUBA	$ 265,571	$ 69,385					$334,956
TEHAMA	$ 169,739	$ 21,397					$191,136
TRINITY	$ 84,040	$ 2,042					$86,082
TULARE	$ 654,882	$ 201,143					$856,025
TUOLUMNE	$ 52,167	$ 16,616					$68,783
VENTURA	$ 219,205	$ 86,376					$305,581
YOLO	$ 195,572	$ 18,408					$213,980
COUNTY TOTAL	$ 36,620,426	$ 8,059,000	$ 200,000	$ 3,987,515	$ 2,000,000	$ 20,000	$50,886,941
DMH ADMIN/SUPPORT	**$ 3,279,000**						**$3,279,000**
							$0
GRAND TOTAL							**$54,165,941**

Criterion 5: Management Systems

State-Level Performance Indicator Description

Goal:	Support activities of the California Mental Health Planning Council (CMHPC) to serve as a statewide catalyst to address the shortage of mental health staff.
Objective:	By June 30, 2007, conduct a Peer Support DACUM (Developing a Curriculum)
Population:	Adults and older adults diagnosed with SMI
Criterion:	Management Systems
Brief name:	DACUM
Indicator:	A completed DACUM submitted to the Department of Mental Health
Measure:	A completed DACUM submitted to the Department of Mental Health
Source(s) of Information:	Work group convened to perform the DACUM process
Special Issues:	
Significance:	The employment of consumers is vital to the transformation of the public mental health system. In order to increase the level of consumer employment in the public mental health system, county mental health departments have developed the peer support specialist position. Understanding this occupational niche is critical to developing additional training programs and being able to expand career mobility opportunities for individuals who are working within the position. A peer support DACUM will allow for a more standardized review of what current peer support professionals are doing in the public mental health system. In addition, a DACUM will enable employers to determine the training that will best enhance the work of peer support, allowing organizations to develop career ladders that link to other professions for consumers who work in these positions.

Fiscal Year: 2007

Population: Adults and Older Adults with SMI

Criterion: Management Systems

(1) Performance Indicator:

1. Develop of Peer Support Curriculum

(2) FY 2005 Actual

(3) FY 2006 Project

(4) FY 2007 Objective By June 30, 2007, conduct a Peer Support DACUM (Developing a Curriculum)

(5) % Attain

Section III--State Plan For Comprehensive Community Mental Health Services For Children

CRITERIA FOR PLAN

With respect to the provision of comprehensive community mental health services to children with a serious emotional disturbance (SED), the criteria regarding a plan are as follows:

CRITERION 1. COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SERVICE SYSTEMS; AND
CRITERION 3. PROVISION OF CHILDREN'S SERVICES (COMBINED)

- **The plan provides for the establishment and implementation of an organized community-based system of care for such individuals.**

- **The plan describes health and mental health services, rehabilitation services, treatment options, employment services, housing services, educational services, medical and dental care, and other available support services to be provided to such individuals with federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act.**

- **The plan provides for activities to reduce the rate of hospitalization of such individuals.**

- **The plan requires the provision of case management services to each individual in the State who receives substantial amounts of public funds or services.**

- **(A) Subject to subparagraph (B) below, provides for a system of integrated social services, educational services, juvenile services, and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs, including services provided under the Individuals with Disabilities Education Act;**

  B) Provides that the grant under section 1911 for the fiscal year involved will not be expended to provide any service of such system other than comprehensive community mental health services; and

  C) Provides for the establishment of a defined geographic area for the provision of the services of such system.

CHILDREN'S ORGANIZED COMMUNITY-BASED SYSTEM OF CARE

All 58 of California's counties currently offer community-based care systems, providing services to the many different service populations that are dependent upon the public mental health system for care. Though the State categorical funds for the Children's System of Care (CSOC) Initiative that had supported system enhancements for over 15 years were eliminated for SFY 2004-05 due to severe budgetary constraints, the context and values of children's services will remain the same at the local levels. Within California our CSOC Initiative has focused upon 1) target populations who are diagnosed as seriously emotionally disturbed (SED); 2) services that are culturally competent, child-centered and family-focused; 3) families being an integral part of service planning, delivery, evaluation and policy discussions; and, 4) the belief that children and youth should, whenever possible, be served at home or in the most home-like setting available. In November 2004, California voters passed the Mental Health Services Act (MHSA), adding additional state funding to the mental health services of California. The Mental Health Services Act promotes these same CSOC values; counties are currently developing their plans for the Community Services and Supports portion of the MHSA. DMH staff will be working with the counties in the future to monitor and provide technical assistance concerning these plans and will encourage the use of CSOC values in the counties' services.

The many years of State-level funding for the CSOC model have provided counties with ongoing service practices and system expectations. To improve upon individual child and youth outcomes and agency resource management, services and supports are most efficient when there is formal collaboration among such agencies. Typical partners at the local level include the following: child and family community based organizations, juvenile justice, education, social services, child welfare mental health, and parent/family representatives. Through the use of Medi-Cal funding, in combination with local county funds and other agency resources earmarked for health services, California counties continue to provide a full continuum of community-based services.

The DMH will continue to fund seven counties with dedicated SAMHSA funding for the development and implementation of specific CSOC program components contained within existing State statutes that define the CSOC Initiative. These seven counties will continue to work on the development of improved systems of care that can be replicated statewide. While MHSA funds will not be specifically earmarked for CSOC programs per se, DMH staff will be working with counties to promote the use of CSOC values in the services for child and youth proposed using MHSA funds.

SERVICE COORDINATION AND ACCOUNTABILITY TO THE CLIENT AND FAMILY

The DMH, in conjunction with the CMHPC, supports service coordination principles stated in the California Mental Health Master Plan. Service coordination should be viewed as "personalized helping" and as the "human link between the client and formal service delivery." This means establishing personal relationships of trust and respect, which requires developing more equal relationships between staff and clients.

All service coordination activities in the counties include some or all of the following elements: case-finding methods to identify clients; a comprehensive assessment of each client; comprehensive service plans; coordination and linkage of services; provision of client advocacy to assure income protection; documentation of service delivery; money management; promotion of self-help resources; and progress reports on service plans.

In 1993, the DMH implemented a major innovation in the Medi-Cal quality assurance process for California's public mental health system, referred to as Coordinated Services. Every individual receiving ongoing SD/MC services was assigned a Coordinator responsible to 1) evaluate, at least annually, the community functioning of the individual; 2) work with that individual to determine his/her goals; 3) develop an overall plan for all SD/MC services county-wide; and 4) approve additional and ongoing provision of SD/MC services. "Ongoing services" was defined as service delivery, other than medication only, beyond 60 days. In addition, the Coordinator assisted individuals with access to services and monitored progress toward the direct consumer's mental health goals. Today, under managed care, counties are required to adhere to the underlying principles of coordinated care, such as individual participation in the treatment plan, rather than using the specific methods previously mandated.

Another change that has positively affected service coordination services in California is the approval and implementation of Targeted Case Management and the Rehabilitation Services Option for SD/MC as part of the Medicaid State Plan. Most service coordination in California is provided in a full-service model under which a service coordinator provides direct services as well as coordination and advocacy. The addition of Targeted Case Management and the Rehabilitation Services Option provides for federal reimbursement of services to improve or maintain community functioning. The definition of case management for our data collection purposes now includes brokerage functions only, including linkage, placement, and plan development to comply with federal Medicaid standards.

For all counties that have been receiving CSOC allocations from DMH to develop and implement systems of care for children with SED, service coordination is considered a key service component. Therefore, service coordination protocols must be included for assessment, linkage, case planning, monitoring, and client advocacy to facilitate the provision of appropriate services for the child and family.

The MHSA requires that families have an active stakeholder role in the planning process for MHSA funding for additional services. Currently counties are engaged in the planning process of developing the Community Services and Supports plan for the MHSA. DMH staff have reviewed each counties planning proposal and encouraged the involvement of families. DMH has also contracted for technical assistance to local parent and family groups so they will can understand and become actively involved in their local MHSA planning process.

STATE-LEVEL COORDINATION FOR EFFECTIVE CSOC

The DMH continues to support inter-agency collaborations that are reflective of local county efforts to integrate services for children. Continued state-level activities include:

- Ongoing involvement with the CDSS on its efforts to launch a first cohort group of counties voluntarily taking on the challenges of redesigning the child welfare services approach within California. (See "Integration with Social Services" section that follows) This includes direct consultation and support with participating counties as well as monthly participation in an inter-departmental deputies meetings addressing the activities of the multiple departments involved with ensuring safe and stable homes for California's children and families;

- Continued involvement with the First Five Commission (formerly known as Proposition 10), working to build expertise and capacity within California's communities to provide quality infant/toddler services through an ongoing 8-county pilot;

- Participation in several workgroups convened by the State Attorney General's Office to address the multiple issues related to domestic violence;

- Continued participation in the Multi-Association Joint Committee (MAJC), which brings together personnel from county-level child welfare, mental health, social services, juvenile probation, and county schools, along with State representatives from the various departments. This group addresses topical issues of the moment, and presses to improve the interagency workings of county- and State-level departments; and

- Continued support of the CMHS-funded "System of Care" and "Circle of Care" sites, to the extent resources allow. This will include working with the existing counties of, Glenn, Sacramento, San Francisco, and Monterey as well as the Circle of Care sites in Humboldt County (United Indian Health Services) and in Alameda County (Native American Health Center).

MHSA

Community Services and Supports refers to "System of Care Services" as required by the MHSA. The change in terminology will differentiate MHSA Community Services and Supports from existing and previously existing System of Care programs funded at the federal, state and local levels.

The MHSA represents a comprehensive approach to the development of community based mental health services and supports for the residents of California. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. To provide for an orderly implementation of MHSA, the California Department of Mental Health has planned for sequential phases of development for each of the components. Eventually all these components will be integrated into comprehensive plans with a continuum from prevention and early intervention to comprehensive, intensive interventions for those in need.

The first component to be implemented was the Community Planning Process. The second component will be those elements of the Act that define the requirements of service delivery to children, youth, adults and older adults with serious emotional disturbances and/or serious mental illnesses. The pertinent sections of the Act are Sections 5, 7, 10 and 15 that add or amend

significant portions of the Welfare and Institutions Codes defining program requirements. County proposals will be evaluated for their contribution to meeting specific outcomes for the individuals served including:

- Meaningful use of time and capabilities, including things such as employment,
- vocational training, education, and social and community activities
- Safe and adequate housing, including safe living environments with family for children
- and youth; reduction in homelessness
- A network of supportive relationships
- Timely access to needed help, including times of crisis
- Reduction in incarceration in jails and juvenile halls
- Reduction in involuntary services, reduction in institutionalization, and reduction in out of-home placements

Plan Review Process

County mental health programs have begun submission of their Three-Year Program and Expenditure Plan for MHSA Community Services and Supports to the Department of Mental Health (DMH) to receive MHSA funding to implement this component.

Introduction to Program and Expenditure Plan Requirements

These Program and Expenditure Plan requirements are intended to build upon and operationalize the concepts in the Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act. These requirements look beyond "business as usual" and are intended to start building a system where access will be easier; services are more effective; out-of-home placements, institutional care, homelessness and incarcerations are reduced; and stigma toward those who are diagnosed with serious mental illness or serious emotional disturbance no longer exists. These requirements are intended to initiate significant changes including:

- Increases in the level of participation and involvement of clients and families in all aspects of the public mental health system
- Increases in client and family operated services
- Outreach to and expansion of services to client populations in order to eliminate ethnic disparities in accessibility, availability and appropriateness of mental health services and to more adequately reflect mental health prevalence estimates
- Increases in the array of community service options for individuals diagnosed with serious mental illness and children/youth diagnosed with serious emotional disorders, and their families, that will allow them to avoid unnecessary institutionalization and out of-home placements

Essential Elements for All Three-Year Program and Expenditure Plans
There are five fundamental concepts inherent in the MHSA that must be embedded and continuously addressed throughout the Program and Expenditure Plans submitted by counties. These include:

- **Community collaboration**: Community collaboration refers to the process by which various stakeholders including groups of individuals or families, citizens, agencies, organizations, and businesses work together to share information and resources in order to accomplish a shared vision. Collaboration allows for shared leadership, decisions, ownership, vision, and responsibility. The goal of community collaboration is to bring members of the community together in an atmosphere of support to systematically solve existing and emerging problems that could not easily be solved by one group alone.

- **Cultural competence**: Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer providers, and family member providers to work effectively in cross-cultural situations.

  Cultural competence includes language competence and views cultural and language competent programs and services as methods for elimination of racial and ethnic mental health disparities. There is a clear focus on improved quality and effectiveness of services. Service providers understand and utilize the strengths of culture in service delivery. Culturally competent programs and services are viewed as a way to enhance the ability of the whole system to incorporate the languages and cultures of its clients into the services that provide the most effective outcomes and create cost effective programs. Identification, development, promulgation, and adoption of culturally competent best practices for care must be an integral part of ongoing culturally competent planning and implementation of the MHSA.

- **Client/family driven mental health system for older adults, adults and transition age youth and family driven system of care for children and youth:** Adult clients and families of children and youth identify their needs and preferences which lead to the services and supports that will be most effective for them. Their needs and preferences drive the policy and financing decisions that affect them. Adult services are client centered and child and youth services are family driven; with providers working in full partnership with the clients and families they serve to develop individualized, comprehensive service plans. Individualized, comprehensive service plans help overcome the problems that result from fragmented or uncoordinated services and systems.

  Many adults with serious mental illness and parents of children with serious emotional disturbances1 have limited influence over the services they or their children receive. Increasing opportunities for clients and families to have greater choices over such things as types of service, providers, and how service dollars are spent, facilitates personal responsibility, creates an economic interest in obtaining and sustaining recovery, and shifts the incentives towards a system that promotes learning, self monitoring, and accountability. Increasing choice protects individuals and encourages quality. (Source: The President's New Freedom Commission on Mental Health – *Achieving the Promise Transforming Mental Health Care in America*.)

- **Wellness focus, which includes the concepts of recovery and resilience:** Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope.

  Resilience refers to the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school and in the community, mental health treatments, which teach good problem solving skills, optimism, and hope can build and enhance resilience in children.

- **Integrated service experiences for clients and their families throughout their interactions with the mental health system:** This means that services are "seamless" to clients and that clients do not have to negotiate multiple agencies and funding sources to get critical needs met and to move towards recovery and develop resiliency. Services are delivered, or at a minimum, coordinated through a single agency or a system of care. The integrated service experience centers on the individual/family, uses a strength-based approach, and includes multi-agency programs and joint planning to best address the individual/family's needs using the full range of community-based treatment, case management, and interagency system components required by children/transition age youth/adults/older adults. Integrated service experiences include attention to people of all ages who have a mental illness and who also have co-occurring disorders, including substance use problems and other chronic health conditions or disabilities. With a full range of integrated services to treat the whole person, the goals of self-sufficiency for older adults and adults and safe family living for children and youth can be reached for those who may have otherwise faced homelessness, frequent and avoidable emergency medical care or hospitalization, incarceration, out-of-home placement, or dependence on the state for years to come. These five fundamental concepts combine to ensure that through MHSA-funded activities, counties work with their communities to create culturally competent, client/family driven mental health services and support plans which are wellness focused, which support recovery and resilience, and which offer integrated service experiences for clients and families.

Services for Children and Youth: The W&I Code, Section 5878.1(a) specifies that MHSA services will be provided to children and young adults with severe mental illness as defined in the W&I Code 5878.2: those minors under the age of 18 who meet the criteria set forth in subdivision (a) of 5600.3—seriously emotionally disturbed children or adolescents. Services will also be provided to children up through age 21 for those who meet the special education eligibility requirements under Government Code Chapter 26.5, Section 7570. Some transition age youth may also be served under W&I Code, Section 5865.1.

The MHSA Program and Expenditure Plan Requirements are based on a logic model that links: (1) community issues resulting from untreated mental illness and a lack of services and supports, (2) mental health needs within the community, (3) the identification of specific populations to be served based upon the issues and needs identified, (4) the programs and services/strategies to be implemented and (5) the desired outcomes to be achieved. In addition to a focus on community issues and outcomes, the MHSA also emphasizes the importance of measuring outcomes achieved by specific individuals and families, including but not limited to: hope, personal empowerment, respect, social connections, independent living for adults and safe living with families for children/youth, self-responsibility, self determination and self esteem for clients and families. Along with other individual and system level outcomes, these individual value-driven outcomes will be incorporated within the outcome measurement system to be developed and implemented under the MHSA. DMH envisions an ongoing process of identifying community issues and unmet needs, focusing upon specific individuals and populations in need based upon these identified issues, developing and implementing state-of the-art service and support strategies and assessing outcomes: all to ensure that counties are providing the highest level of quality care possible in the most efficient and effective ways. It is further envisioned that as a part of the ongoing quality improvement process, data and feedback on the individual, community and system levels are used to refine and improve services and supports. Plans for addressing individual quality of care issues are a part of this ongoing process.

Specific Populations by Age Consistent with MHSA and DMH Priorities:

- **Children and youth between the ages of 0 and 18, or Special Education Pupils up to age 21, who have serious emotional disorders and their families, who are not currently being served**.

- **Transition age youth** between the ages of 16 and 25, who are currently unserved or underserved who have serious emotional disorders and who are homeless or at imminent risk of being homeless, youth who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems and youth involved in the criminal justice system or at risk of involuntary hospitalization or institutionalization.

- **Adults with serious mental illness** – including adults with a co-occurring substance abuse disorder and/or health condition who are either:

- **Older adults 60 years and older with serious mental illness** – including older adults with co-occurring substance abuse disorders and/or other health conditions – who are not currently being served and have a reduction in personal or community functioning, are homeless, and/or at risk of homelessness, institutionalization, nursing home care, hospitalization and emergency room services. Older adults who are so underserved that they are at risk of any of the above are also included. Transition age older adults (as described above) may be included under the older adult population when appropriate.

Each individual identified as part of the initial full service population must be offered a partnership with the county mental health program to develop an individualized services and supports plan. The services and supports plans must operationalize the five fundamental concepts

identified at the beginning of this document. They must reflect community collaboration, they must be culturally competent, they must be client/family driven with a wellness/recovery/resiliency focus and they must provide an integrated service experience for the client/family.

CHILDREN'S REHABILITATION SERVICES

California's 58 county departments of mental health, and the hundreds of community-based certified providers, continue to offer a wide range of service options. The menu of services includes the continuum of "habilitative" services, designed to engage children, youth and families in services and supports that return these consumers to positive developmental trajectories. California law requires that a minimum array of services be available for children with SED, to the extent resources are available. Included in the counties' menu of services are: pre-crisis and crisis services; assessment; medication education and management; individual, family and group therapies; day treatment programs; service coordination; 24-hour treatment services; and support services designed to alleviate symptoms and foster the development of age-appropriate, cognitive, emotional and behavioral skills necessary for success. Within the last several years there has been an increasing demand for school based mental health services, and mental health services and supports that are offered within a "wraparound service approach."

County departments of mental health continue to participate in the county's "court schools" or "juvenile justice programs" which provide combined educational and treatment services for adolescents with serious legal, educational and medical conditions such as drug/alcohol abuse with co-occurring mental/emotional disorders. County mental health staff provide services within juvenile halls, after school programs, and coordinated case management services through existing juvenile justice programs operating with state grant funds.

As California enters its third year of significant budget shortfalls the local capacity to provide the entire range of "habilitative" mental health services to all children and youth will be severely tested.

INTEGRATION WITH SOCIAL SERVICES

The California Department of Social Services (CDSS) reexamination process of the entire child welfare system within California concluded in September of 2003 with the final "Redesign Plan", and has been coordinated with the federal requirements (U.S. Department of Health and Human Services) for program improvements based upon the Child and Family Services Reviews (CFSR) and California's own legislature's proposal regarding program improvements.

The principles of the federal review framework contain many of the same elements as previous mental health initiatives, including:

- Family-centered practices;
- Community-based services;
- Individualized services for children and families; and
- Strengthening the capacity of parents to provide for their children's needs.

As California and its counties respond to the requirements of these various elements, DMH, county mental health departments and the California Mental Health Planning Council will be working collaboratively with this larger stakeholder group to address the components related to improving access to mental health services. DMH is active at both the state interdepartmental deputies meetings coordinating these efforts, and has directed resources towards the 11 counties that have elected to aggressively reconfigure their systems to be more in line with objectives of the CDSS Redesign Plan. As part of the "roll-out" of the child welfare redesign, DMH continues to work with the California Institute for Mental Health (CIMH) to assist the counties in adopting evidenced based practices targeting children and youth served by the child welfare system. These technical assistance efforts have been a valuable means for counties to integrate the latest federal and State service and funding initiatives into their CSOC systems.

HEALTHY FAMILIES PROGRAM

California established the Healthy Families Program (HFP) in 1998 to provide low-cost health insurance under Title XXI of the Social Security Act to children under the age of nineteen whose families do not have insurance, do not qualify for zero share-of-cost Medi-Cal and whose income is at or below 250% of the federal poverty level. Services are provided by health plans under contract with the Managed Risk Medical Insurance Board (MRMIB), the state agency that administers HFP. MRMIB is responsible for most budgeting related to HFP; however, DMH is responsible for budgeting the HFP funds for the mental health benefit for children with serious emotional disturbances (SED). The HFP health plans are responsible for providing basic mental health benefits to HFP enrollees who do *not* meet the SED criteria and are also responsible for the first thirty days of psychiatric inpatient services. The costs associated with these benefits are not included in the DMH estimate. Medically necessary mental health services for HFP enrollees with SED are the responsibility of the county mental health plans.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

The EPSDT benefit is a required service under the federal Medicaid (Medi-Cal) program. EPSDT services were expanded in 1995 by the Department of Health Services (DHS) in accordance with federal regulations and statutes that require states to provide any medically necessary services, including mental health services, to correct or ameliorate the health or mental health condition of a full-scope Medi-Cal beneficiary under the age of 21. DHS concluded that, in order to meet the needs of children and youth with serious emotional disturbances (SED), the logical providers for these expanded EPSDT services were the traditional providers of services to this population i.e. the county mental health departments. DHS provided DMH and the counties with both the State and the federal funding necessary to meet this mandate.

Upon implementation of the specialty mental health managed care program in fiscal years (FYs) 1997 and 1998, EPSDT services were provided as a component of the Medi-Cal Specialty Mental Health Consolidation program that provides services in a managed care environment in counties through local mental health plans (MHPs). MHPs became responsible for all EPSDT services for eligible beneficiaries who met the medical necessity criteria for MHP specialty mental health services, including any services needed to correct or ameliorate the beneficiary's mental health condition. Services provided by MHPs are Short Doyle/Medi-Cal (SD/MC) services under the Rehabilitation Option. Each county implemented plans for meeting the

additional demand for services and providing access to care. It should also be noted that services to EPSDT beneficiaries might include services directed toward substance abuse issues for beneficiaries with a dual diagnoses of mental illness and substance abuse if such services are necessary to the attainment of the mental health treatment goals.

In July 1999, following the preliminary injunction in the Emily Q. vs. Belshé lawsuit, MHPs also became responsible for the provision of the EPSDT supplemental specialty mental health service, Therapeutic Behavioral Services (TBS). TBS allows for the delivery of intensive one-to-one services for children/youth with SED who meet the TBS criteria and who are experiencing a stressful transition or life crisis and need additional short-term support to prevent placement in a group home of Rate Classification Level 12 or above, a locked facility for the treatment of mental health needs (including acute care), or to enable a transition to a lower level of residential care. These services are not stand alone services and are intended to supplement other EPSDT specialty mental health services.

State General Fund (SGF) amounts for counties for expanded EPSDT services were determined after a baseline was established representing the county's responsibility to maintain their mental health service funding levels prior to EPSDT expansion. This baseline represents the State Fiscal Year (SFY) 1994-95 SD/MC allowable cost report settlement amount adjusted for cost of living (home health market basket index) and for the amount allocated to MHPs for non-hospital Fee-for-Service Medi-Cal services to this population under the specialty mental health managed care program. Local funds are used as match for FFP up to baseline levels. Effective SFY 2002-03, MHPs were required to provide ten percent of the State's matching requirement for growth in the cost of EPSDT services above the SFY 2001-02 level.

The current arrangement regarding State funding of expanded EPSDT mental health services was made with the understanding that once the financial risk for these services could be reasonably assessed, a fixed funding amount would be transferred to the counties. Beginning with SFY 2003-04, DMH initiated a monthly distribution of 95 percent of the SGF above the baseline that was established for each county prior to EPSDT expansion and based on SD/MC approved claims data for the MHP. This process replaced the previous SGF distribution process for EPSDT to MHPs through an annualized initial distribution of 75 percent of expected payments.

Although a monthly distribution of EPSDT SGF is made to MHPs as previously described, final payment continues to be part of the cost report settlement process. MHPs submit claims for services through the SD/MC claims processing system for reimbursement of the FFP portion of the service. DMH's current cost settlement methodology for settling costs for SD/MC is used for all reimbursement for EPSDT services. It should also be noted that State funding for expanded EPSDT services is not intended to replace financial resources available from other sources, i.e. grants or through shared resources at the local level.

MEDICAL AND DENTAL SERVICES

The majority of children served by the mental health system (approximately 70 percent) are eligible for California's Medi-Cal (Medicaid) program, which provides essential medical care and services to preserve health, alleviate sickness, and mitigate handicapping conditions for children and their families on public assistance, or whose income is not sufficient to meet their

medical needs. The covered services are generally recognized as standard medical services required in the treatment or prevention of diseases, disability, infirmity or impairment. California's program is quite comprehensive and provides services in all major disciplines of health care.

The current Denti-Cal program, which is part of the Medi-Cal program, provides a comprehensive array of dental services that includes, but is not limited to, preventive services, restorations, root canals, crowns, dentures once every five years, and orthodontia care. The current dental fiscal intermediary, Delta Dental of California, operates a Beneficiary Services Unit that provides, among other services, dental referrals for beneficiaries and a beneficiary outreach component that focuses on underserved counties in California.

CALIFORNIA AIDS PROJECT

The DMH has responsibility for the California Aids Project. The project provides mental health counseling and support to those affected by, or at risk of, the HIV virus and AIDS. The main focus of the program is to provide counseling and mental health services to support people who are HIV/AIDS Positive, at risk of AIDS/HIV and the partners and family members needing mental health services, counseling and support for AIDS/HIV and related concerns.

Currently DMH contracts with fourteen agencies to provide these services. The range of these counties and agencies extend from San Diego County to Sacramento County. Some of these agencies are county mental health departments while others are non-profit or private service agencies. Some counties subcontract with agencies in their surrounding county.

The Budget Act of 1988 allocated $1.5 million dollars to DMH. That funding is also counted toward the match requirement for the federal Ryan White AIDS funding. The funding has remained constant for over fifteen years and is awarded on a three-year cycle from the State General Fund. The counties or agencies reapply to renew their contract near the end of the third FY. Agencies are required to submit a scope of work plan, budget detail and narrative at the time they renew their contract with DMH.

There are numerous ongoing challenges related to the provision of AIDS/HIV supportive services including a sharp rise in AIDS/HIV and resulting increased demand for services as well as the shift and change in the character of the risk groups. It is estimated that there will be a one in four new AIDS/HIV infections reported each year, in youth ages 13-21, and these youth will not be accessing services in proportion to their rising infection rates. As of November 30, 2005, California has received case reports for 139,094 AIDS diagnoses and 39,717 HIV infections. White males, age 25 or older at diagnosis, account for most AIDS (N=73,531) and HIV (N=16,398) case reported to date. Fifty-eight percent (58 percent) of individuals reported with AIDS are known to be deceased. Due to this large number, some innovative approaches have developed and been considered, such as services based upon the Harm Reduction Model which can utilize such controversial strategies as the needle exchanges for IV drug users who are high risk of AIDS/HIV infection.

It is also become common practice to link other services with HIV/AIDS counseling, such as vocational services and housing.

INFANT PRESCHOOL FAMILY MENTAL HEALTH INITIATIVE

With $1.5 million in funding from the California Children and Families Commission (CCFC), DMH continued the Infant Preschool Family Mental Health Initiative (IPFMHI) during SFY 2004-05. The 8 participating pilot county departments of mental health included Alameda, Fresno, Humboldt, Los Angeles, Riverside, Sacramento, San Francisco, and Stanislaus. All counties have completed their work and reported their findings to CCFC.

The designated contractors are California Institute of Mental Health (CIMH) and West Ed. West Ed is completing its work in June 2005, with final reports on sustainability of infant, preschool and family mental health efforts in the 8 pilot counties, and configuration of final reports on financial feasibility, use of local resources, and approaches to training providers, to be posted on the CCFC website in late 2005. CIMH is continuing to actively work with DMH to develop training, technical assistance, and outcome development for the ten Special Needs Demonstration sites affiliated with School Readiness programs that were identified through a Request for Proposals process. The 10 sites, which held several planning meetings to date, were fully implemented in December 2005. Initial activities included training for mental health screening. DMH (Dr. Penny Knapp) has provided materials, assisted in identifying trainers, and participated actively in the development of the Special Needs portion of the Initiative.

In this phase of the work, and in collaboration with the Special Needs project coordinator, IPFMHI assisted in the development and support of the mental health and behavioral health components of the Special Needs Project demonstration sites. The IPFMHI ensured that effective and proven mental health assessments, evaluation and services are fully integrated into the design, implementation, outreach, training and evaluation of the project. This includes collaboration with the Special Needs Evaluator to ensure that mental and behavioral health indicators were included in the evaluation, design and tools used in the project. The IPFMHI consulted on mental health and behavioral elements of First 5 projects such as the Kit for New Parents, and made presentations at the State, local and regional level.

EARLY MENTAL HEALTH INITIATIVE

The Early Mental Health Initiative (EMHI) is part of DMH's continuum of mental health services for children. As a prevention and intervention service for children, the EMHI was established to fund programs that serve children in kindergarten through third grade (K-3) who are experiencing mild to moderate school adjustment difficulties. The purpose of EMHI is to fund programs that provide services to selected students that will enhance their social and emotional development and increase their likelihood of future school success.

There are several key components of the EMHI:

- Provide school-based and low cost services to students in kindergarten through third grade experiencing mild to moderate school adjustment difficulties;
- Provide services in a culturally competent manner;
- Provide services to appropriate students in the target population from low-income families;

- Provide services to appropriate students in the target population who are in out-of-home placement or are at-risk of out-of-home placement;
- Encourage the involvement of parents and teaching staff to build alliances to promote student's mental health and social and emotional development;
- Provide services in collaboration with a cooperating mental health entity such as a county mental health department or a private non-profit agency;
- Use a systematic selection process of students most likely to benefit from program participation;
- Change the traditional roles of mental health professionals and use alternative personnel, such as child aides, to provide direct services to students;
- Provide ongoing supervision and training of child aides by credentialed school psychologists, social workers, or school counselors in collaboration with professional staff of the cooperating mental health entities;
- Provide ongoing monitoring and evaluation of program services; and
- Ensure implementation of programs that are based on adoption or modification, or both, of existing program models that have been shown to be effective and which are based on sound research.

During SFY 2005-06, EMHI provided $10 million for programs throughout the State and served approximately 10,547 of the State's estimated 567,000 children in kindergarten through third grade at risk of school adjustment difficulties. Services were provided at 309 school sites located in 62 elementary school districts within 25 counties. The areas served range from sparsely populated, isolated rural districts to highly populated urban districts. The 2005-06 State Budget included a $5 million increase in EMHI funding that supported 150 new school sites.

Each year since 1988, data from pre- and post- instruments have been collected and analyzed from state-funded programs to determine program effectiveness. This data has consistently yielded statistically significant levels (.001) of improvement in school adjustment by the students who participated in the program. In addition, the DMH collects school district demographic information and qualitative data related to services twice a year.

EDUCATIONAL SERVICES FOR CHILDREN

Individuals with Disabilities Education Act / Special Education Program

The major categorical program within California serving special education pupils at the community level is known as our "AB 3632 program". The Individuals with Disabilities Education Act (IDEA) is the federal law (Part 300 of Title 34 of the Code of Federal Regulations) that ensures the provision of mental heath services to pupils in special education who require such services in order to benefit from their education. This act entitles disabled students to a "free and appropriate public education." As a result of the federal IDEA entitlement, the California Legislature passed AB 3632, Chapter 1747, Statutes of 1984, "Interagency Responsibilities for Providing Services to Handicapped Children," Chapter 26.5 of the Government Code, which combines educational and mental health resources in an

interagency delivery model to provide mental health services to eligible students for special education. Prior to this legislation, it was the responsibility of the Local Education Agency (LEA) to provide these services. The interagency program now designates the local mental health programs as being responsible for providing mental health services to special education pupils who have been determined to need mental health treatment to benefit from their education. County mental health agencies may not limit or deny services to eligible pupils, and may not, by law, bill the pupils' family for these services. Currently the program serves approximately 26,000 special education pupils annually.

An Individualized Education Plan (IEP) team determines the eligibility of the pupil and recommends appropriate services in the least restrictive environment. The implementing regulations, Title 2, Division 9 of the California Code of Regulations, became final on August 9, 1999. These regulations require the LEA to ensure that 1) appropriate educational assessments have determined that a child is special education eligible; 2) the school has provided counseling and guidance services; and 3) such services are not sufficient to meet the pupils' needs. Once these requirements have been met, a referral may be made to the Local Mental Health Department (LMHD). In support of the Special Education Program, the California Department of Education, along with DMH, conduct collaborative interagency compliance complaint investigations to determine if program implementation by the LEAs and LMHDs meets the requirements of State and federal law.

In the past year, the Governor and Legislature of California have been examining the structure and functioning of mental health services delivered under the provisions of IDEA. As part of the current state budget process, various options are being reviewed for the delivery of such services. In the coming months, further clarification of the means by which these services will be delivered in the future are expected.

Reforms In Educational Rights For Foster Youth

Effective January 1, 2004, new duties and rights related to the education of foster youth (wards and dependents) were imposed upon California county departments. This bills reforms of the handling of the education placements of these vulnerable youth. Though not directly impacting LMHD's, the bill will result in more stable placements, complete and timely transfers of educational records, and continuity of the educational placements. These changes will allow LMHD's to deliver improved services through the avoidance or reduction in out-of-community placements that so frequently have lead to significant service disruptions. As mentioned in the above EPSDT section, LMHP's have continued to expand school site services for eligible children and youth. At this time state departments of education and social services are working along with DMH to develop improved tracking systems within our data bases to evaluate the impacts of this legislation.

CO-OCCURRING SUBSTANCE ABUSE AND MENTAL DISORDERS (DUAL DIAGNOSIS)

The increasing awareness and acknowledgement of persons exhibiting co-occurring substance abuse and mental disorders, or dual diagnosis, is an issue of national concern. It is estimated that approximately 60 percent of persons with a serious mental illness also have a substance abuse

problem, and that up to 90 percent or more of the highest cost users of mental health services, including forensics consumers, also abuse substances.

The Department of Alcohol and Drug Programs (ADP) and DMH have long recognized the critical need of working cooperatively to provide quality treatment services to individuals with co-occurring disorders. Building on the efforts that have taken place since 1995, DMH and ADP, in collaboration with the County Alcohol and Drug Program Administrators Association of California, the California Mental Health Directors Association, the Alcohol and Drug Program Institute, and the California Institute for Mental Health, convened the Co-Occurring Joint Action Council, which meets quarterly.

The Council's joint vision statement — "One Team with One Plan for One Person" — states that "Each individual receives a comprehensive assessment that results in the formation of an interdisciplinary and possibly interagency team that will develop one individualized treatment plan for that person within a reasonable period of time. This plan will specify all necessary services and supports to be delivered by the single interdisciplinary service team that has all the needed skill sets and the right members in place from each agency. The individual client will have a strong voice in shaping the plan in development and implementation. The plan is expected to evolve as needed as that person progresses."

Additional efforts by the DMH in the area of co-occurring disorders include the following:

- The DMH has permanently setting aside $8,059,000 of its annual SAMHSA Block Grant for allocation to counties to support existing efforts in providing integrated treatment services for adults with co-occurring disorders. Counties are required to submit to DMH expenditure plans describing their intended use of the additional funds for the DMH's review and approval.

- The DMH received one of SAMHSA's Evidence-Based Practices grants, now in its third year of implementation, to 1) provide training and technical assistance to implement the Integrated Dual Diagnosis Treatment (IDDT) model in eight sites throughout California; 2) evaluate the implementation process and fidelity to the IDDT model; and 3) develop the infrastructure to foster statewide implementation of evidence-based practices.

- The DMH and ADP received a Second National Policy Academy grant for addressing co-occurring disorders from SAMHSA on October 12, 2004. The purpose of National Policy Academy grants is to assist States in building the necessary infrastructure and policy development for addressing co-occurring disorders. California recently submitted to SAMHSA its Action Plan for improving access to prevention, specialty treatment, and other services for persons with co-occurring disorders. To better address State-level policy and program issues on co-occurring disorders, DMH and ADP merged the National Policy Academy into the Co-Occurring Joint Action Council.

- In the spring of 2005, a workgroup tasked to implement the Substance Abuse and Mental Health Service Administration (SAMHSA) COD state action plan began meeting. Members of the SAMHSA COD National Policy Academy and the joint association representatives

coalesced into the forum called the Co-Occurring Joint Action Council (COJAC). The COJAC will be adding representation to broaden input and to facilitate moving the action plan forward with the deepest and broadest input possible.

Resource-Building Treatment Strategies

Youth with co-occurring disorders need special resources to overcome each of their disorders. The following are resource-building treatment strategies developed by the California Mental Health Directors Association, Children's System of Care/Adult System of Care, Transition Age Youth (TAY) Subcommittee, published April 29, 2005:

- There should be no wrong door as an entryway to treatment. Whatever agency the youth uses to request help must ensure that the youth has access to services from partner agencies. These services may include mental health and substance-related treatment as well as housing, training, rehabilitation resources, and therapeutic courts. This is critical because when the youth needs help, it must happen in the moment or the opportunity may be lost. With the youth's permission, there should be collaboration and coordination of the youth's treatment plan. Substance abuse programs, from the continuum of abstinence to harm reduction, recognize that recovery is incremental and the road to recovery has its ups and downs. Providers should strive to reduce barriers to the provision of appropriate, coordinated, and integrated services for TAY youth, which include different funding streams, philosophical differences, lack of cooperation and collaboration, and the lack of cross training.

- Once the youth acknowledges the substance use problem, and agrees to receive support, all significant social supports of the TAY youth should be involved in the treatment planning process including the youth, his or her family, school, social services or probation, mental health, and Alcohol and Other Drug (AOD) providers as well as other members of the youth's support network. Providers must acknowledge that the youth is the holder of the privilege, and thus he or she must agree to how the treatment is organized. In the event the youth does not acknowledge the need for services, all providers and members of the support system should continue to encourage the individual until engagement and maintenance in treatment occurs.

- Youth who are homeless or otherwise without stable living conditions will find it difficult to embrace recovery from substance use. Therefore, ensuring that basic needs are met is a critical step in providing care to these youth. This is especially true for TAY with a background in the foster care system whose priorities may be focused on obtaining the basic necessities of living.

- Because of TAY's age-appropriate need for independence, providers should work to balance client-driven treatment planning with a solid supportive structure to prevent the individual from becoming "lost" in the process of recovery.

- Foster youth are most vulnerable to treatment failure because they may not have the financial and emotional resources to support them in recovery. The youth who suffered trauma from growing up in a domestically violent or an abusive or negligent home is

especially vulnerable. If appropriate, family support services can strengthen the youth and the entire family system. By building on the strengths of the youth, his or her family, and his or her support system, counselors can draw on the resources that each participating party brings to the intervention. Using a strength-based approach, the treatment team can develop and implement a realistic, attainable plan for recovery that improves the functioning of each participant.

Treatment Strategies

- Place a strong emphasis on family involvement. Youth need to feel secure and feel the support of his or her immediate family members and broader social network. No matter what the circumstances of the relationships within the family are, the youth and the family should be engaged in securing solutions to a better relationship. For a variety of reasons, some youth have disengaged from their families and/or support groups and will not have functioning social networks. In these situations, efforts should be made to help the youth build natural supports as part of the treatment process.

- Develop an individualistic case plan. Each client has unique circumstances with individualized sets of goals and objectives. A "cookie cutter" or "one size fits all" approach will not be effective. As Dr. Pablo Stewart has noted, there are instances where the substance use is a manner of self-medicating for long standing untreated mental illnesses. It is for this reason that MH and AOD staff need to work closely together and use a universal chart where entries from both Departments are available to the other and to additional participants of the treatment team.

- Explore the strengths of the youth. Recovery based goals will be founded upon the youth's vision of his or her future. The treatment planning team will need to focus the discussion in a hopeful and supportive manner.

- Providers need to consider that what is happening for the youth may in fact be a "system issue," meaning that the youth may be acting out symptoms for other family members or for a significant other. By including the whole family group and/or the significant other, there is a greater likelihood that a true solution will be found. A youth's crisis is an opportunity for the family constellation to enhance communication and improve functioning for the future.

- Woman and girls with co-occurring disorders often come from a background of family violence, and the sequelae of trauma endured may be what is driving the mental illness or substance involvement.

JUVENILE JUSTICE AND MENTAL HEALTH

The lack of funding and qualified personnel to provide mental health services to incarcerated youth remains a significant challenge for California counties. In the past year, there has been considerable concern regarding the mental health services available to youth in the California Youth Authority, the state operated youth correction system, as well as in local juvenile halls and youth juvenile justice programs. When delinquent youth, who pose such threats to public safety

or self, cannot be dealt with in community probation programs counties must provide detention settings to manage their care. The lack of funds (e.g. Medicaid) restricts the robustness of the care provided. The MHSA noted that the priority child and youth populations to be addressed are those individuals without existing funding sources. With the passage of the Mental Health Services Act, DMH expects that many counties will use this opportunity to further develop the mental health services that they offer youth in the juvenile justice system.

The many years of "collaboration", mandated in most of California's innovative programs legislation has paid dividends in the areas of improved relationships and jointly run local programs. The diminishing pool of local resources required renewed commitment to shared planning activities is essential services and supports are to remain accessible. The DMH, along with its technical assistance contractors, county mental health directors, representatives of California's Board of Corrections, the Chief Probation Officers Association, and a statewide parent advocacy group, retain the following agenda of goals and objectives:

- Identify opportunities for association collaborative efforts that will impact relevant service systems;

- Promote promising practices and evidence based practices;

- Develop training, technical assistance and research priorities;

- Encourage and support the development of a statewide plan, which includes the collaboration of the State agencies, for serving this population; and

- Act as an advisory committee to other entities engaging in activities that will impact the mental health and substance abuse service needs of youth in the juvenile justice system.

Along with the formation of this ad hoc advisory group, the DMH and county mental health departments have focused considerable technical assistance and training activities at the local level. This has included the development of newsletters on available funding streams for developing services and regional presentations on evidenced based practices for this service population. DMH has devoted considerable technical assistance resources to helping counties explore the options for new service delivery options utilizing MHSA funds.

CALIFORNIA WORK OPPORTUNITIES AND RESPONSIBILITY TO KIDS (CalWORKS)

On August 11, 1997, the Governor signed Assembly Bill (AB) 1542 into law, which is the primary vehicle used to overhaul California's existing welfare program operating under the authority of the federal Temporary Assistance for Needy Families (TANF) program. This bill replaced the Aid to Families with Dependent Children (AFDC) and the Greater Avenues to Independence (GAIN) programs with the CalWORKs program. Under CalWORKs, cash aid to families is time-limited and able-bodied adults in the family must meet certain work requirements to remain eligible. County welfare departments, under the supervision of California Department of Social Services (CDSS), administer CalWORKs. Mental health services, to reduce barriers to employment, are a critical component of CalWORKs.

The major focus of CalWORKs is to prepare clients for work and assist them to obtain and maintain employment so they can effectively support their families. The State Legislature determined mental health and substance abuse treatment are necessary components of CalWORKs and included the provision of these services in the law. To the extent that funding is available, counties will provide for the treatment of mental or emotional difficulties and substance abuse that may limit or impair a client's ability to make the transition from welfare to work or retain employment over a long period of time. Available mental health services must include assessment, case management, treatment and rehabilitation services.

County welfare departments and the county mental health departments are mandated to jointly develop mental health assistance services. CalWORKS also requires county welfare departments and the county alcohol and drug departments to collaborate to ensure an effective system is available to provide for evaluations and substance abuse treatment. In addition to ongoing technical assistance, CDSS maintains oversight of the funding through reports submitted by the county welfare departments. The DMH provides assistance by participating in interagency meetings with California Department of Alcohol and Drug Programs, CDSS, and other State agencies. This interagency workgroup is dedicated to sharing information about new financial support sources, technical assistance, research, and program and policy development.

The primary funding source for the CalWORKs program is the federal TANF Block Grant. CDSS is the lead agency that draws down and distributes the federal funds to county welfare departments. There is a State and County Maintenance of Effort (MOE) for the TANF Block Grant. General Funds (GF) for CalWORKs substance abuse services and mental health services are $48,870,000 and $59,916,000, for FY 2005-06, respectively, $ 48,125,000 and $62,777,000 for FY 2006-07. These funds are used to meet the TANF Block Grant MOE requirements.

Reporting on the number of CalWORKs clients receiving mental health and substance abuse treatment services began in 1999. The report includes the number of clients referred for and receiving mental health and/or substance abuse treatment services during the month. In addition, counties are required to report the mental health CalWORKs services to the Client and Services Information System (CSI).

CHILD WELFARE SERVICES

Staff of the State and local Departments of Mental Health are working with staff of the State and local Departments of Social Services/Child Welfare to implement a series of reforms within the existing Child Welfare Services programs. Due in part to the change in administrations during a recent election, and the ongoing fiscal restraints, the previously developed Child Welfare Design has been scaled back to address improved risk assessment, differential response, and permanency issues with a sub-set of county programs. Knowledge accrued through this process will be shared as "outcomes" become available.

EMPLOYMENT SERVICES FOR YOUTH

On September 30, 2003, the California Workforce Investment Board received a grant from the U.S. Department of Labor's Office of Disability Employment Policy to improve transition outcomes for youth with disabilities. California will address services to youth through resource mapping that extends beyond federal to state program allocations and will develop a state unified plan for transition services for youth with disabilities. The DMH will be meeting with these other key partners in the project:

- Workforce Investment Youth Council;
- Workforce Investment Youth Council Institute;
- Department of Rehabilitation;
- Department of Education;
- California Community Colleges;
- California Institute on Human Services;
- California Foundation for Independent Living Centers; and
- World Institute on Disability.

California will conduct resource mapping of the existing youth service infrastructure. DMH staff will review the resource mapping and make recommendations for an action plan. The State's efforts will 1) emphasize vocational as well as academic learning as valuable opportunities for youth, 2) prioritize work experiences for in-school youth, and 3) institutionalize collaborations of employment services with disability-related services and education. Demonstrations will be conducted in three local workforce investment areas and will support federal and State investments in specialized educational and vocational experiences for youth with disabilities.

YOUTH PILOT PROGRAM--DEMONSTRATION OF COLLABORATIVE, INTEGRATED CHILD AND FAMILY DELIVERY SYSTEMS

With the passage of AB 1741 (Chapter 951, Statutes of 1993), California's Health and Human Services Agency was authorized to develop a pilot program for six counties interested in implementing integrated child and family delivery systems. The Youth Pilot Program (YPP) encourages pilot counties to seek waivers to existing State and federal requirements, if necessary, to overcome the categorical restrictions they often create within the context of a "seamless" human services delivery system.

The YPP builds upon the successes of the CSOC and is supporting the development of institutional and administrative reforms that improve client outcomes. The YPP allows participating counties to explore alternative and innovative ways of providing comprehensive, integrated services to high-risk children and families with multiple needs to help prevent or limit problems, rather than responding to the consequences. The program also provides counties and local agencies the ability to make decisions locally about the best use of State and human services funds to better meet needs and build upon community strengths. Under this program, pilot counties develop alternative administrative and program management techniques suitable for replication in other counties across the State.

The pilot program was statutorily extended to allow for continued county innovations until 2004. Since the passage of AB 1741, additional companion bills have followed that allow for additional counties to participate in this innovative human services pilot project, with two smaller north State rural communities now participating. The focus of their activities has been the development of streamlined state allocation and reporting methodologies, functional "one stop" centers for services and supports, and improved interagency management of residential and wraparound placements for youth.

AB 1741, now called AB 2026 through recent legislation, has been extended until Jan 1, 2009.

ACTIVITIES TO REDUCE HOSPITALIZATION FOR CHILDREN

Children and youth with SED typically have needs in many areas, including the home, school, and community. Their needs cannot be met solely by the mental health system. Rather, what is required is the joint involvement of other agencies and systems, including special education, child welfare, health, and juvenile justice. In order to promote inter-agency and inter-system collaboration within local children's systems of care, California requires individual counties to form interagency case management councils. These local councils work toward coordinating resources for specific target population children who are concurrently using the services of more than one agency.

The goal is to reduce long-term hospitalization and group home placement in favor of using the multi-disciplinary resources of the county, and to treat the child within the community, whenever possible. Members of local interagency case management councils include, but are not limited to, representatives from special education, juvenile probation, social services, and mental health agencies. Members have the requisite authority to commit resources from their agency toward an interagency service plan for the child and his/her family. More counties are recognizing the key role that mobile crisis units can play in stabilizing a child/youth within their communities, delaying or making unnecessary restrictive inpatient hospitalizations.

The MHSA emphasizes community based rehabilitative services over treatment in hospitals and other institutional settings. This community-based emphasis is due to the past efforts in California to find the least restrictive setting appropriate for meeting the needs of the child or youth. As part of the MHSA planning process, many stakeholders are brought together in the local community to assist in the identification of unserved and underserved children and youth. The MHSA specifically notes that education, social services, and law enforcement must be part of this stakeholder process. With the participation of these groups, California hopes to continue in its efforts to reduce hospitalization to those situations where it is the best clinical option for the needs of the child or youth.

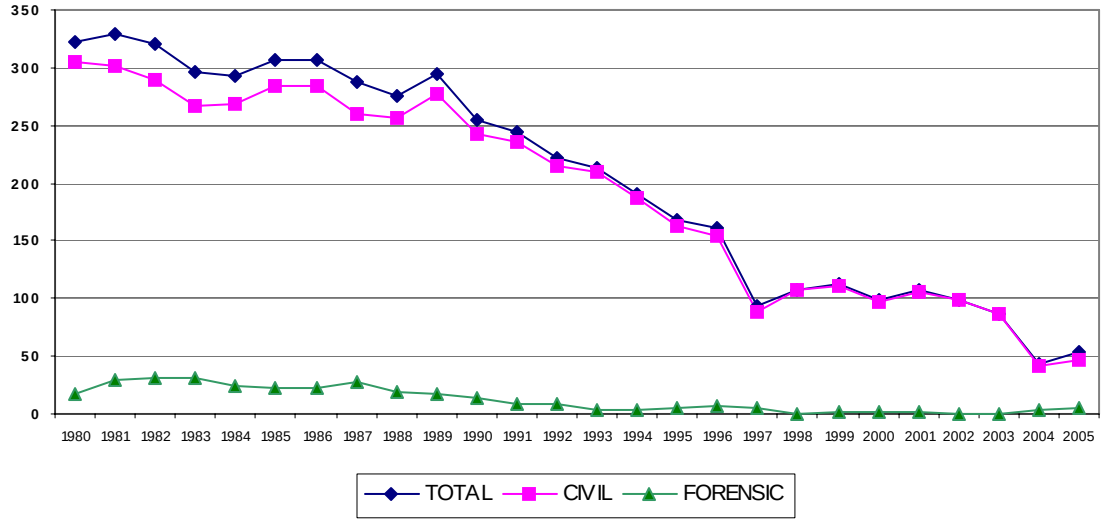
REDUCED STATE HOSPITALIZATION

A significant component of the 1991realignment legislation was its impact on the State Hospitals. Prior to realignment, the State allocated to each county a historically fixed number of civil commitment State Hospital beds. The State Hospitals serving persons who are civilly committed are Metropolitan and Napa. The counties had little financial stake in, or programmatic control over, these beds. Realignment shifted bed funding to counties along with

the discretion over where to spend those funds to serve the needs of persons with serious mental illness. The result has been dramatic in its impact on these two State Hospitals.

Counties have developed community-based programs that provide alternative care to State Hospitalization. These programs are enriched by the continuum of services such as crisis intervention, outpatient services, day treatment and community outreach. This approach has reduced the number of children in State Hospitals. As of May 2006, there were 29 children in State Hospitals. This is compared to 168 children in June 1995 and 255 children in June 1990. This gives California one of the lowest State Hospital utilization rates in the nation.

State Hospital Population For
Persons Less Than 18 Years of Age
June 30th, 1980 - 2005



In an effort to increase efficiency of available resources, schools have been certified as clinics to provide school-based mental health services through local mental health programs. In addition, some group homes have also been approved by the DSS to serve children with SED who, in the absence of these services, may have required hospitalization. These group homes are required to have annual certification from the local mental health department that their mental health program meets the statewide criteria. California continues to develop new programs and quality assurance mechanisms to avoid unnecessary hospitalization.

For all counties that have received CSOC allocations to develop and implement local systems of care for children with SED, service coordination is considered a key component. As such, service coordination protocols must be included for assessment, linkage, case planning, monitoring, and client advocacy to facilitate the provision of appropriate services for the child and family.

COMMUNITY TREATMENT FACILITIES

The Community Treatment Facilities (CTFs) category of care has been under development since 1985 with the passage of SB 876. The intent of the CTFs was to create a complementary package of mental health treatment services delivered within a licensed community care facility serving children and youth with the program certified by the DMH. The CTF model sought to integrate within a single setting the services and supports of the foster care and mental health systems. The CTF model features joint monitoring and oversight from the CDSS and DMH.

In 1988, additional amendments to the statutes added mental health oversight on the use of restraint, seclusion, and psychotropic medications in CTFs. Further amendments to the category were added in 1992 when the facility definition was restructured to become a secure treatment setting. During the years of discussion regarding the appropriate level of mental health treatment, CTFs evolved into a richly staffed, secure treatment environment that replicates many medically licensed health facilities, yet retains it's "community-based" feel. Later deliberations led to the current regulatory scheme and the statutory 400-bed limit on the number of CTF beds to be implemented statewide. Five CTFs are currently licensed and operating. They include: Starlight in San Jose, Seneca in the City of San Francisco, Vista Del Mar in the Los Angeles region, Seneca-Oak in Concord, and Starview in Torrance. Starlight is licensed for 36 beds, Seneca for 22 beds, Vista Del Mar for 21 beds, Seneca-Oak for 18 beds and Starview for 40 beds.

TRANSITIONAL SERVICES

DMH staff are involved with ongoing workgroups at the State level that address the needs of youth transitioning between the child and adult systems. The Children and Family Program Policy Section oversees the CSOC initiative for children and youth diagnosed with SED, and acts as a catalyst for multiple State-level activities, including the development of a resource guide aimed at assisting youth and workers in navigating the systems. Transitional services have become a focus with the passage of the MHSA; the MHSA designates that the needs of transition age youth ages 16 to 25 be addressed in the county's plan for Community Services and Supports. Currently counties are in the process of designing these plans. In the current year, counties are submitting these plans, and DMH staff will be working with the counties to implement new efforts to serve these populations.

The incorporation of recent findings regarding "success" for youth and the relationship to their educational achievements will drive more work in the area of ensuring that youth diagnosed with SED have sound educational placements and transition plans. The California Department of Education funded a study that examined policies and practices that negatively impact the academic success of youth living in foster care placements. This study proved to be the impetus for Assembly Bill 490, referenced above in the education section. Existing California special education law requires that appropriate transition-age youth services be provided to pupils with their needs listed on their IEPs. AB 490 will ensure that there is additional focus at the local level for youth served within the foster care system.

ELIMINATING MENTAL HEALTH DISPARITIES TO RACIAL ETHNIC POPULATIONS/ CULTURAL COMPETENCE

California is one of the most demographically diverse states in the nation. California's population has grown by over 21 percent since 1990. The following tables show the diversity of the State population. California is now a multicultural majority state. Multicultural populations now comprise more than 51% of the State population. The State's Hispanic/Latino population has grown by 50 percent, from 7.7 million in 1990 to nearly 11.7 million in 2003, followed by the Asian/Pacific Islander population, up over 61 percent from 2.7 million to 4.4 million in the same time period. The Hispanic category includes all persons who indicated Hispanic or Latino in the 2000 Census. The remaining categories include only those persons who did not identify themselves as Hispanic or Latino. In the 2000 census, California's combined ethnic and racial populations became the majority; this trend continues in 2005. These changes make it imperative that mental health policies, services planning are designed with this growing diversity in mind.

TOTAL POPULATION
BY RACE AND AGE GROUP
July 1, 2005

RACE/ETHNICITY	Total	AGE GROUP		
		0-17	18-64	65+
Total	37,372,444	10,509,172	22,819,942	4,043,330
White	17,731,217	3,647,457	11,358,694	2,725,066
Hispanic	12,300,819	4,798,582	6,855,127	647,110
Asian/pacific Islander	4,684,467	1,302,059	2,940,608	441,800
Black	2,433,988	709,080	1,520,429	204,479
American Indian	221,953	51,994	145,084	24,875

The following table shows the distribution of the unduplicated clients served in State Fiscal Year 2003-04. The client population reflects the diversity of the State population although not all groups are represented proportionally to the State population.

UNDUPLICATED CLIENTS BY RACE / ETHNICITY AND AGE GROUP
FISCAL YEAR 2003-2004

Race / Ethnicity	Total	Age Groups					
		0 - 8	9 - 17	18 - 59	60 - 64	65 +	Age Unknown
Total	628,928	84,027	141,876	376,600	11,189	13,303	1,933
White	259,522	25,427	47,220	173,674	5,205	7,442	554
Hispanic	154,638	29,924	46,270	74,003	1,688	2,062	691
Black	110,886	15,641	25,941	66,569	1,182	1,275	278
American Native	5,220	704	1,199	3,195	53	58	11
Vietnamese	6,050	272	627	4,538	396	208	9
Chinese	5,540	583	771	3,516	246	413	11
Filipino	4,966	310	747	3,571	126	197	15
Cambodian	3,244	123	522	2,415	129	52	3
Laotian	2,842	108	344	2,228	104	53	5
Korean	2,114	149	282	1,503	89	89	2
Japanese	1,093	37	128	800	40	87	1
Asian Indian	621	58	99	428	17	16	3
Amerasian	454	54	102	281	10	6	1
Other Asian or Pacific Islander	7,816	335	913	5,942	440	175	11
Samoan	316	56	110	144	2	1	3
Hawaiian Native	191	29	45	113	2	2	-
Guamanian	172	29	39	100	3	-	1
Multiple Races or Ethnicities	16,748	4,201	5,113	7,105	158	99	72
Other	8,506	707	1,335	5,677	449	299	39
Unknown / Not Reported	37,989	5,280	10,069	20,798	850	769	223

The DMH is currently developing the most effective, efficient mental health service system that will meet the diverse cultural and linguistic needs of the State's population. Both access to care and effectiveness of care are affected by the level of cultural competence that State and local providers are able to deliver. Providing culturally competent care is viewed as an overall quality of care issue. California has taken a developmental approach to moving culturally competent services forward. The DMH has assumed a leadership role by establishing the Office of Multicultural Services (OMS) at the Director's Office level.

For the past six years, the DMH OMS has had in place an active Cultural Competency Advisory Committee (CCAC) to provide assistance and advice in developing culturally competent mental health services. The CCAC is chaired by the Chief of the Office of Multicultural Services and is composed of representatives from the CMHDA, consumers and family members of both adults and minor children, community organizations and their representatives, County Ethnic Services Coordinators, and the academic community. The

membership of the CCAC is ethnically and racially diverse. Since the release of the 2001 U.S. Surgeon General's *Supplemental Report on Mental Health: Culture, Race, and Ethnicity*, and the 2003 DHHS report, *The President's New Freedom Commission on Mental Health Achieving the Promise: Transforming Mental Health Care in America*, the DMH OMS with the CCAC has been working to incorporate information and recommendations into state and local level cultural competence planning.

Other ongoing activities of the CCAC and the Office of Multicultural Services include:

- Addressing ongoing multiple strategies to eliminate disparities in access to and quality of care for the State's multicultural populations, including a specific focus this year on Latino population access to care issues;

- Embedding cultural competency into program policy plans at the State and local levels, including the CMHPC's Master Plan, Evidence-Based Practice strategies, trainings, and Quality of Care redesign efforts; as well as including a major focus on cultural competence and reducing ethnic/racial disparities under the Mental Health Services Act;

- Providing training and support to consumer and family members organizations for inclusion of more multicultural voice in their planning and embedding of cultural competency in their planning;

- Planning for more specific training in the area of cultural competency; and

- Implementing a process in 2003 for revising the DMH Cultural Competence Plan Requirements; this is the third revision of the CCPR since first issued in 1997.

The DMH is aware of and concerned with the current mental health disparities that exist in our state for multi cultural communities. The Mental Health Services Act (MHSA), which California voters approved in November of 2004, provides an opportunity to transform the mental health system in California. Through the MHSA, DMH is addressing Goal 3 of the President's New Freedom Commission on Mental Health Report "to eliminate disparities to racial ethnic communities in mental health." In addition, DMH's Vision Statement and Guiding Principles for MHSA implementation states that "as a designated partner of this critical and historic undertaking, the DMH will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system."

To this end, the MHSA-Community Services and Supports Three-Year Program and Expenditure Plan Requirements, when finalized, will address the elimination of mental health disparities, and include the following components:

- In selecting the initial population, counties must give specific attention to reducing racial/ethnic disparities.
- There are specific requirements to address unserved and underserved populations that have been adversely affected by lack of access to mental health services.

- There are several requirements counties must address regarding historically unserved populations.
- There is a technical assistance document entitled *Embedding Cultural Competence in MHSA*, as a resource for counties in planning and implementation efforts.
- There are requirements for counties to provide an analysis of the organization and service provider strengths and limitations in terms of capacity to meet the needs of racially and ethnic diverse populations in the county. This analysis must address the bilingual staff proficiency for threshold languages.
- There are specific requirements for counties to compare and include an assessment of the percentages of culturally, ethnically and linguistically diverse direct service providers as compared to the same characteristics of the total population who may need services in the county, and the total population currently served in the county.
- There are specific requirements for counties to provide an analysis and include a discussion of the possible barriers their system will encounter in implementing the programs for which funding is requested and how counties will address and overcome these barriers and challenges. Challenges may include such things as difficulty in hiring staff due to human resource shortages, lack of ethnically-diverse staff, lack of staff in rural areas and/or on American Indian reservations and rancherias, difficulties in hiring clients and family members, need for training of staff in recovery/wellness/resiliency and cultural competence principles and approaches, and need to increase collaborative efforts with other agencies and organizations.
- Current work on the performance outcomes in both the individual and system level performance outcomes will include attention to data collection to inform future planning to eliminate mental health disparities.

In addition to the above activities, the DMH provided funds to local mental health agencies for training on cultural and language competency. The OMS is currently working with CIMH's CMD on a grant from The California Endowment to assess effectiveness of cultural competence efforts at the local level, and identify training and technical assistance needs and development of county cultural competence profiles. The DMH, local CMHDA Ethnic Service Managers/Coordinators (ESM), and the CCAC have been working collaboratively with the CIMH CMD to address ongoing statewide planning for moving forward cultural competency efforts. A statewide meeting was held with key stakeholders in October 2003 with the CMHDA, ESM, CIMH CMD and DMH OMS to address ongoing strategic planning for eliminating racial ethnic disparities in mental health.

The DMH has also designated the Chief of OMS to serve as the State liaison and consultant to county Ethnic Service Managers/Coordinators; the State Quality Improvement Council; the State Compliance Advisory Committee; the California Health and Human Services Agency, Committee to Eliminate Racial, Ethnic Health Disparities; the Women's Mental Health Policy Council; the Statewide Planning Committee for Cultural Competence and Mental Health Summits; and the CIMH CMD.

OTHER SUPPORT SERVICES: COUNTY OPERATIONS

County Operations is a unit within the DMH Systems of Care Division. The unit's staff is organized regionally, with the "North" section staff assigned to two main sub-regions: 1) Northern Region- primarily rural counties in the northern part of the state, and 2) Bay Region-the counties comprising the greater San Francisco Bay Area. The "South" section staff are also sub-divided and assigned to cover two main sub-regions: 1) Central Region- which includes most of the counties in California's Central Valley and many in the Sierra Nevada foothills, and 2) Southern Region- serves the large population base represented by southern California counties.

From a broad perspective, the primary goals and objectives of the DMH County Operations Unit include assisting and supporting California's county-organized community mental health programs in meeting their programmatic goals to provide high quality public mental health care. This assistance and support occurs primarily through established collaborative relationships with ongoing close communications between County Operations staff and the administrative staff of each county mental health program. Indeed, County Operations staff serves as the primary contact point between DMH and the counties. In its day to day functioning, County Operations staff provides consultative and technical assistance services to county mental health programs in a wide variety of subject areas, from managed Medicaid ("Medi-Cal") mental health to SAMHSA, from contract monitoring to policy, fiscal, and regulatory consultation. In the event the questions or issues raised by the county indicate a need for coordination or connecting/brokering to other resources, County Operations staff also serves the important liaison role of connecting county staff to the appropriate DMH resources of people and/or information best suited to assist the county. The County Operations liaison role is also bi-directional, with county mental health programs often supplying information to DMH to assist in the development of responsive and relevant statewide programs and policy.

Specifically, though not an all-inclusive list, County Operations staff:

- Exchange information with county mental health program staff;
- Advocate for local mental health program issues;
- Respond to local mental health program inquiries, providing consultation, information, technical assistance and guidance;
- Conduct visits to county mental health programs statewide;
- Participate on a wide variety of stakeholder committees and attend meetings;
- Provide input and perspective to DMH policy development that is enriched by County Operations' uniquely close relationship with, and understanding of, counties' specific mental health program needs, concerns and experiences;
- Review and approve mental health plans and modifications to plans;
- Develop, review, and approve county performance contracts;
- Facilitate timely and accurate county program reporting;
- Provide consultation to county mental health programs on federal and state laws, regulations, and policies;
- Assist county mental health programs in achieving quality improvement goals;

- Assist county mental health programs in achieving cultural competence goals; and
- Collaboratively analyze, develop and implement problem solving strategies on issues identified by county mental health programs.

CHILD/YOUTH AND FAMILY PERFORMANCE OUTCOMES

The design and implementation of appropriate performance measurement systems are critical components of the transformational agendas reflected in the President's New Freedom Commission Report on mental illness, the Institute of Medicine's Six Aims for Improvement and California's Mental Health Services Act[1] (MHSA). To ensure measurement systems are consistent with the recovery/wellness-based philosophies for children and youth, modification of evaluation strategies are expected over time. California continues to align itself and participate in performance measurement designs at the national level and intends to keep its measurement strategies consistent with Federal reporting requirements such as the Uniform Reporting System (URS) [supported in part through the Data Infrastructure Grant (DIG)], and the National Outcome Measures (NOMS). Additional detailed information on performance measurement and the MHSA for California's public mental health system is available on the DMH website at http://www.dmh.ca.gov/poqi/ and http://www.dmh.ca.gov/MHSA/default.asp, respectively.

During SFY 2005-06, DMH continued to use the Web-Based Data Reporting System (WBDRS) to collect data using a point-in-time method to target all consumers receiving face-to-face mental health services. The DMH Consumer Perception Survey was conducted during a two-week period in November 2005 and May 2006. Again, the most recent versions of the Youth Services Survey for Families (YSS-F) and Youth Services Survey for Youth (YSS) were used to assess perceptions of quality and outcomes of care. The surveys are currently available in English, Spanish, Korean, Tagalog, Chinese, and Vietnamese[2].

In addition to the Consumer Perception Survey, California's MHSA has provided support for transforming California's Mental Health System to provide a more comprehensive approach to the development of community based mental health services and supports for the residents of California. With respect to performance outcomes, this approach includes an emphasis on accountability to measure performance, as well as to improve quality and align management and administrative practices with quality services, productivity and positive outcomes.

Since the design of performance measurement systems is a highly complex endeavor, DMH assembled a Performance Measurement Advisory Committee (PMAC) to advise DMH regarding technical issues related to performance measurement such as selection of indicators, assessment tools and other protocols for data collection, as well as information systems/software design and development for data collection, management, analyses and reporting. Selection of PMAC members was based on type and level of experience, areas of expertise and collective ability to represent the diverse persons and geographic areas within California.

To set a framework for designing performance measurement systems, DMH developed a Tri-Level Performance Measurement Paradigm,[3] which is being used to develop measurement

[1] http://www.dmh.ca.gov/MHSA/docs/meeting/12-17-2004/Mental_Health_Services_Act_Full_Text.pdf

[2] The Consumer Perception Surveys are posted on the DMH website at http://www.dmh.ca.gov/POQI/perception_survey.asp

[3] For more information, visit http://www.dmh.ca.gov/mhsa/docs/Perf%20meas%20document%20for%20posting%205%2012%2005.pdf

strategies at the public/community impact level, the mental health system accountability level and at the individual client level. This paradigm is being used by the PMAC to design measurement methods at each level. As a starting point, the PMAC is currently focused on implementing performance measures at the individual client level.

Based on the successful Integrated Services for Homeless Adults with Serious Mental Illness (AB 2034) evaluation model[4], the PMAC developed initial requirements for measuring individual-level performance outcomes for a small, selected target population, called Full Service Partners (FSPs), as specified in the DMH *"Mental Health Services Act Community Services and Supports, Three-Year* Program and Expenditure Plan Requirements, Fiscal Years 2005-06, 2006-07, 2007-08[5]". For all FSPs identified and served, providers must submit the data captured by three types of assessments: a Partnership Assessment Form, a Key Event Tracking and a Quarterly Assessment[6]. The Partnership Assessment Form gathers history and baseline information about each FSP and the Key Event Tracking and the Quarterly Assessment gather follow up information. The domains that are tracked by these assessments include residential setting, education, employment, sources of financial support, legal issues/designations, emergency interventions, health status and substance abuse.

A new information technology solution has also been developed that supports the collection of the repeated-measures, FSP accountability data which described above. The Data Collection and Reporting System (DCR) is California's first module toward Electronic Health Records (EHRs) for the public mental health system. The DCR is aligned within the State's vision for a comprehensive, interoperable electronic mental health record system. By leveraging Extensible Markup Language (XML) technology, DMH will be able to exchange, manage, and integrate data, as well as distribute information system changes. This solution offers both a centralized, web-based application and methods that ensure interoperability between disparate county/provider systems. The DCR was designed by using a hybrid data model that combines (1) the traditional relational data model, maximizing performance and scalability with (2) support for the XML data type to ensure system flexibility to changes in business/data needs. Consistent with DMH's vision for a comprehensive and fully interoperable information system, DMH also expects to incorporate the existing WBDRS within the DCR to provide continued support for survey administration methods, including those used to report Youth Services Survey for Families (YSS-F) and Youth Services Survey for Youth (YSS) data.

STATE QUALITY IMPROVEMENT COUNCIL

The State Quality Improvement Council (SQIC) assists the California Department of Mental Health (DMH) in continuously improving the quality of mental health services in the public mental health system. Appointed by the Director of DMH, the SQIC is comprised of DMH staff, local mental health department staff, clients, family members, advocates, and other stakeholders who work on quality improvement projects toward the goal of system transformation. Within the transformational agenda, quality improvement projects are undertaken to develop a system that is client and family centered, culturally competent,

[4] http://www.ab34.org/

[5] http://www.dmh.ca.gov/mhsa/docs/CSSfinal_8.1.05.doc

[6] View the assessments at http://www.dmh.ca.gov/POQI/full_service_forms_POQI.asp

accessible, responsive, efficient, effective, and incorporates recovery/resiliency/wellness-based philosophies.

Current national and state trends have resulted in the development of guidelines and recommendations for system improvements and transformation. These include the Six Aims for healthcare delivery and quality care discussed in the Institute of Medicine's Crossing the Quality Chasm's (2001), the six goals for a transformed mental health system discussed in the President's New Freedom Commission Report on Mental Illness, the Mental Health Statistics Improvement Program (MHSIP) Quality Report Toolkit, the National Outcomes Measures, and the Uniform Reporting System, supported by the Data Infrastructure Grant. The State Quality Improvement Council is using many of these guidelines and recommendations. One example of the Council's work is the development of a "crosswalk" translating the Six Aims of the Institute of Medicine's Crossing the Quality Chasm's report into applicable Aims for mental health delivery and quality care.

Many exciting changes in California's public mental health system are currently being introduced as a result of the passage of Proposition 63 in November 2004, now known as the Mental Health Services Act (MHSA). Since passed, the DMH in conjunction with numerous stakeholders have conceptualized a transformed mental health system based on wellness and recovery principles. The MHSA philosophy especially reflects the importance of processes that are client and family driven and that are individualized to provide "whatever it takes" activities in support of recovery.

The State Quality Improvement Council reviews data, processes and other information, and recommends strategies to bring about quality change. The council's focus is on quality improvement and quality promotion. The SQIC is being reinvigorated with new methods and a new focus in order to meet the challenges of the transformative process being instituted in state and local public mental health systems per the MHSA. This new focus builds on the previous work of the SQIC, and serves as an example of the quality improvement process.

To accomplish its mission, the Council collaborates with existing quality-related committees and councils such as the Compliance Advisory Committee, the External Quality Review Organization, the Performance Measurement Advisory Committee, the California Mental Health Planning Council, and the County Mental Health Directors Association. The Council also reviews data gathered by Medi-Cal claims, the Client and Services Information System, and the Statewide Performance Outcome Measurement System, etc. to identify successes and problems related to quality processes. In this way, the SQIC acts as a feedback mechanism to suggest process improvements and interventions that will generate added and/or improved quality across mental health systems

Finally, an important goal of the SQIC is to provide education about the interpretation and contextualization of data and other information. As a result, participants and other interested parties improve their understanding of data. Through the increased understanding of data, speculation about what data means is reduced, decision support is improved, and the design of subsequent quality improvement processes is enhanced.

EXTERNAL QUALITY REVIEW ORGANIZATION

The External Quality Review Organization (EQRO) will objectively assess quality, outcomes, timeliness of and access to the services provided by 56 California Mental Health Plans (MHPs) that contract with the Department of Mental Health (DMH) to provide Medi-Cal specialty mental health services to Medi-Cal eligible individuals. To make this assessment, the EQRO will conduct annual external quality reviews that include:

- Assessment of DMH-specified Performance Measures (PMs);
- Assessment of MHP-selected Performance Improvement Projects (PIPs);
- Periodic evaluation of selected aspects of each MHP's on-going internal Quality Improvement (QI) system and annual review of each MHP's progress on any related plans of correction;
- Review of each MHP's health information system capability to meet the requirements of the Medi-Cal specialty mental health services program; and
- Review of each MHP's most recent compliance review performed by the DMH Program Compliance Division, Medi-Cal Oversight Unit, and each MHP's progress on any related plans of correction.

The EQRO will prepare a report annually on each MHP that comprehensively assesses the overall performance of the MHP in providing mental health services to Medi-Cal beneficiaries. The individual MHP reports will utilize the EQRO's own assessment of each MHP in light of the review components described above. EQRO will also prepare an aggregate report for the State based on the information gained in the assessments of the individual MHPs.

The EQRO will provide up to four hours of technical assistance and consultation for each MHP annually. The intent of this activity to meet the individualized quality improvement needs of each MHP and to maximize the utility of the external review activity as a quality improvement learning experience.

Because of the unique nature of the Medi-Cal managed mental health care system, calculation of performance measures is done by DMH using claims data obtained from the MHPs. Thus, in order to fully assess MHP performance, the EQRO will review and assess various DMH data systems and processes in addition to the MHPs' system for reporting claims data. The EQRO will prepare an annual report that comprehensively assesses the overall performance of DMH in this capacity.

The first year of reviews will utilize protocols for validation of performance measures and performance improvement projects and an information system assessment instrument developed by DMH, in addition to any review protocols or instruments developed by the EQRO for use in other areas of the review. In subsequent years, the EQRO will work with DMH, MHPs and other

stakeholders to edit the DMH-developed protocols and information system assessment instrument as necessary to maximize their effectiveness in collecting pertinent information to meet regulatory requirements and adapt their content to the California public mental health system.

In order to successfully accomplish the above the EQRO will be required to work closely with the DMH Contract Administrator and other key DMH staff as needed to plan and coordinate activities. The EQRO will also be expected to attend up to four statewide meetings annually to provide training and technical assistance on the EQR process to MHPs and other stakeholders. Periodic status reports will be required by DMH.

State Plan for Comprehensive Community Mental Health Services for Children

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

State-Level Performance Indicator Description

Goal:	To create a comprehensive community mental health system that promotes resiliency for children, youth and transition-age youth (TAY) with serious emotional disturbance (SED) and their families.
Objective:	By June 30, 2007, counties throughout California will have established Full Service Partnership programs to provide resiliency and recovery-focused, comprehensive services, including mental health and other community support services, to previously un-served or at risk individuals. By June 30, 2007, DMH will establish a process for tracking the actual number of individuals served quarterly in Full Service Partnership programs established with Mental Health Services Act funds and report that information in the State Implementation Plan.
Population:	Children and youth and TAY with SED
Criterion:	**Comprehensive Community-Based Mental Health Service Systems**
Brief name:	Full Service Partnerships
Indicator:	Number of individuals enrolled in FSP's
Measure:	Number of FSP's
Source(s) of Information:	Quarterly Actuals submitted by counties
Special Issues:	
Significance:	Full Service Partnership programs established pursuant to the MHSA are expected to deliver the most comprehensive array of services available based on an individual's specific needs. These programs may use MHSA funds to provide "whatever it takes" to help persons achieve their goals and improve the quality of their lives. Services are not limited to mental health services but are expected to address other needs including but not limited to housing, employment, education, co-occurring conditions, physical health, involvement with the criminal justice system, etc. It should be noted that counties are required to collect and report individual outcome information on persons served in Full Service Partnership programs, including their housing and employment status.

Fiscal Year: 2007

Population: **Children, Youth and TAY with SED**

Criterion: Comprehensive Community-Based Mental Health Service Systems

(1) Performance Indicator:

1: CSS Plans

(2) FY 2005 Actual Not applicable.

(3) FY 2006 Project Not applicable.

(4) FY 2007 Objective By June 30, 2007, counties throughout California will have established Full

Service Partnership programs to provide resiliency and recovery-focused, comprehensive services, including mental health and other community support services, to previously un-served or at risk individuals. By June 30, 2007, DMH will establish a process for tracking the actual number of individuals served quarterly in Full Service Partnership programs established with Mental Health Services Act funds and report that information in the State Implementation Plan.

(5) % Attain

Criterion: 1. Comprehensive Community-Based Mental Health Service System

Name of CMHS National Outcome Measures: 2-a. and 2-b. Reduced Utilization of Psychiatric Inpatient Beds – Readmissions to State Psychiatric Hospitals within 30 Days and 180 Days

Population: Children with SED

California has not set specific goals to date because the absolute and relative numbers of persons served in State Hospitals is very low. A recent NASMHPD report shows that California's State Hospital utilization for voluntary and civil commitments is among the lowest in the country. The number of hospital days per 100,000 children and youth is 444 while the national average is 1,590. This is the second lowest rate among 30 states reporting. The rate for adults in California is 918 while the national average is 5,360. This is the third lowest rate among 39 states reporting for adults.

The performance indicator is stated as the percent of persons discharged who are readmitted. As the number of civil commitments in the State Hospitals continues to decline, the number of discharges also declines, and hopefully the number of readmissions also declines. However, when the numbers are small, a difference of one or two people can change the direction of readmissions from decreasing to increasing. Following are data from the Block Grant application to illustrate this point.

Readmission to State Psychiatric Hospitals within 30 Days for Children

Fiscal Year	2003-04 Actual	2004-05 Actual	2005-06 Target
Performance indicator	1.1%	0.0%	0.0%
Numerator	1	0	0
Denominator	86	20	20

Readmission to State Psychiatric Hospitals within 180 Days for Children

Fiscal Year	2003-04 Actual	2004-05 Actual	2005-06 Target
Performance indicator	2.3%	0.0%	0.0%
Numerator	2	0	0
Denominator	86	20	20

The Department cannot establish a goal to which the state will be held based on so few people. The Department can state that it will strive to decrease the readmission rates, and that there is a goal to keep the readmission rate below 15 percent. This would allow for variation that might take place in individual years.

In addition to the instability of trends based on so few people, there are serious program concerns. At some point, there are a minimum number of beds that must be maintained for persons who are seriously ill and who require 24-hour services for an extended period of time. The people who use these beds are very seriously ill, and typically there are no other options in

the community. Therefore, it is not surprising that a certain number may return to the hospital, despite county efforts to keep them out of the hospital. Perhaps a different approach is needed for states where the state hospitalization rate is very low.

Criterion: 1. Comprehensive Community-Based Mental Health Service System

Name of CMHS National Outcome Measures: 3. Evidence-Based Practices

Population: Children with SED

Combining the resources from the Data Infrastructure Grant (DIG) and the Mental Health Services Act (MHSA), the Department has modified its data systems to enable the reporting of Evidence–Based Practices (EBP). These changes were combined with other changes that were needed to the data system. They are being implemented for SFY 2006-2007. Since 58 county systems are being modified to report these new data elements, we expect some lag in reporting over the next fiscal year. The Department developed the reporting guidelines and standards last fiscal year and has been aggressively training counties by Web conference and regional in-person trainings. These trainings are intended to guide and direct counties on making system modifications. Training and technical assistance are a significant component of the second DIG grant for FY 2006-07 to ensure accurate data collection and reporting. During FY 2006-07 as counties start reporting, the Department will continue to provide technical assistance to counties as they implement the changes and monitor reporting to identify any reporting problems early. The Department expects to report limited baseline data for FY 2006-07.

Criterion: 1. Comprehensive Community-Based Mental Health Service System

Name of CMHS National Outcome Measures: 4. Client Perception of Care

Population: Children with SED

Fiscal Year	2003-04 Actual	2004-05 Actual	2005-06 *Estimate*	2006-07 Target
Performance Indicators	63.9% (+/- 1%)	63.7% (+/- 1%)	64.3% (+/- 1%)	64% (+/- 1%)
Numerator	6,966	15,566	17,016	
Denominator	10,909	24,431	26,462	

California continues to assess consumer perception semi-annually during the months of May and November. As expected, client perception of care remained consistent between FY 2003-04 and FY 2004-05. The estimate for FY 2005-06, based on preliminary data, also remains at approximately 64% (+/- 1%). The estimates for the numerator and denominator, above, are arrived at by doubling the numbers from our November 2005 data collection period. A May 2006 survey collection was conducted, however data from these surveys are not yet available for analysis. The target for FY 2006-07 is to maintain the (approximate) 64% positive response rate of the 2003-04, 2004-05, and 2005-06 fiscal years.

These data are used in reports to the counties throughout California to report on clients' perceptions of care. The California DMH encourages counties to use this information locally to make program improvements to benefit clients and family members. Additionally, the data are used to inform California's many stakeholders such as the State Quality Improvement Council, California Mental Health Planning Council, Performance Measurement Advisory Committee, and the newly established Oversight and Accountability Commission for Mental Health Services Act statewide performance oversight processes.

Criterion 3: Children's Services

State-Level Performance Indicator Description

Goal:	Expand community-based mental health services to Transition-Aged Youth (TAY) with SED.
Objective:	By June 30, 2007, update baseline data on the number of TAY youth with SED aged 16 to 25 years, as defined by the Mental Health Services Act (MHSA) and include race/ethnicity in the analysis.
Population:	Children and youth diagnosed with SED
Criterion:	Children's Services
Brief name:	TAY Services
Indicator:	The number of children and youth aged 16 to 25 with SED who are receiving services by race/ethnicity.
Measure:	The number of children and youth aged 16 to 25 with SED who are receiving services by race/ethnicity.
Source(s) of Information:	Client and Services Information (CSI) Data System
Special Issues:	
Significance:	

Fiscal Year: 2007

Population: **Children, Youth and TAY with SED**

Criterion: Children's Services

(1) Performance Indicator:

1: TAY Services

(2) FY 2005
Actual Not applicable.

(3) FY 2006
Project Not applicable.

(4) FY 2007 By June 30, 2007, update baseline data on the number of TAY youth with SED aged 16 to 25 years, as defined by the Mental Health Services Act (MHSA) and include race/ethnicity in the analysis.

(5) % Attain

CRITERION 2. MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY

- **The plan contains quantitative targets to be achieved in the implementation of such system, including the numbers of such individuals residing in the areas to be served under such system.**

- **The plan contains an estimate of the incidence and prevalence in the State of serious emotional disturbance (SED) among children.**

OVERVIEW OF CALIFORNIA'S DATA SYSTEMS

There are several automated systems at the State level that contain client, service and fiscal data from State Hospitals and county mental health programs. The data systems for State Hospitals have been developed around the Admission/Discharge/Transfer (ADT) System, which is an on-line real time system for State Hospitals. The system includes basic demographic characteristics of all clients, dates in and out of the hospital, dates and types of legal class changes, and dates of ward changes. The function that tracks legal class and ward changes allows for billing and fiscal reporting since there is a daily rate established for each ward. Data from the ADT system are linked with the Cost Recovery System to generate billing data. A number of other functions have been automated that tie to the ADT system, such as Trust Accounting, Pharmacy, Laboratory, and Physician's Orders. There are plans to continue data system development to support increased efficiency in State Hospital operations.

Wellness And Recovery Model Support System (WARMSS)

The WARMSS is a comprehensive computer software program that records each patient's assessed needs as derived during initial treatment team planning sessions; patient-generated life goals; goals for each treatment session or class; available types and providers of treatment; a schedule and rosters of patients assigned to treatment sessions; degree of patient achievement of each treatment goal; changes in goals; and measures of progress in treatment. When WARMSS is deployed system-wide, DMH will be able to monitor and summarize data concerning amounts and types of treatments provided and the effectiveness of these treatments. The system is consistent with the wellness and recovery models of mental health that place special emphasis on client-driven treatment goals and services and in which services are often provided in treatment malls with a campus atmosphere and flexibility in tailoring available treatment to individual needs. WARMSS was installed at Metropolitan State Hospital in April 2005 and will be deployed in all state hospitals by early 2006.

Recovery-Model Outcome Reports (formerly "SHOES")

Long Term Care Services will combine data generated by the WARMSS system with other centrally gathered data to write reports that were formerly conducted as part of the State Hospital Outcome and Evaluation System (SHOES). The SHOES project was redesigned in the past year to be consistent with the Recovery Model of mental health treatment that the Department of

Mental Health has adopted. Long Term Care Services will write monitoring and evaluation reports that expand upon the current "Questions and Answers About the Safety and Effectiveness of California State Hospital Services" report series begun in September 2004 to answer questions including:

- What proportion of patients met their goals for mental health recovery?
- What treatments were provided to patients who met and did not meet goals?
- What system results are achieved (reductions to length of stay and return rates)?

While the operational data systems for State Hospitals have been developed by and are maintained by DMH staff, county mental health programs each develop their own systems and send extracts from their systems to DMH in specified formats. There are two primary data systems used for county mental health data. The Client and Service Information (CSI) system is a statistical reporting and includes client and service information about all persons served in county mental health programs. The Medi-Cal system is actually composed of several files that include all persons who are eligible for Medi-Cal, and the Medi-Cal claims that have been paid for specialty mental health services.

Both of these systems are used extensively by DMH staff to calculate indicators for the Statewide Quality Improvement Committee, for program planning, monitoring, and to respond to requests from the legislature, state and federal agencies, county programs, consumers, family members, and other interested stakeholders.

In addition to client level data systems, there are two other systems that include county data. The County Financial Reporting System (CFRS) is a year-end cost report of all costs expended by county mental health programs. Costs are reported in the same categories that are used for statistical reporting. The Provider and Legal Entity File identifies the actual provider site as well as the legal or corporate entity, or county, that "owns" the provider. The CSI system is based on provider reporting while the CFRS is based on legal entity reporting. Through the Provider and Legal Entity file, costs reported to the CFRS by legal entity can be linked to services reported in the CSI by provider. Through this linkage process it is possible to estimate the cost of services provided to specific groups of individuals, such as youth, or people with certain diagnoses. Preliminary efforts to link the data sets for several projects have proven to be challenging. There are frequently minor differences in spelling of names or transpositions of dates that cause records not to match when they should. DMH staff will continue to work in this area to improve the matching process so that the benefit of linking the data systems can be realized.

As the data systems are fully implemented and integrated, their use is increasing. With the increasing use of the data, the importance of complete and accurate data also increases. The DMH will be developing a data quality program focusing on CSI to ensure the accuracy of the data.

Health Insurance Portability and Accountability Act

The DMH continues efforts on the implementation of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). The provisions require establishment of national standards for electronic health care transactions and national

identifiers for providers, health plans, and employers along with the security and privacy of health data. Adopting these standards improves the efficiency and effectiveness of health care systems by encouraging use of electronic data interchange (EDI).

When a HIPAA rule becomes final, DMH (as health plan and healthcare provider) has two years to achieve compliance. DMH compliance efforts have included a series of information exchanges and interactions with business partners to establish implementation guidelines.

- The Privacy Rule was final In December 2000, final modifications were released in August 2002, and the compliance date was April 2003. DMH met the compliance date. Privacy training was provided to DMH staff at headquarters and all State Hospitals. The Notice of Privacy Practices form was provided to each DMH State Hospital patient and posted on the DMH website. The Authorization for Release of Information form was updated to meet HIPAA requirements and is available at each State Hospital.

- The TCS rule was final in October 2000 and final modifications were released in February 2003. DMH requested and was granted a compliance extension to October 2003 (which DMH met). The State is using a phased-in approach to achieve HIPAA compliance for the Short-Doyle Medi-Cal claims processing system. Phase I implementation was achieved by using a translator to convert inbound HIPAA compliant claim transactions (837) to the proprietary SD/MC claim format used by the Department Health Services- Information Technology Short-Doyle (DHS-ITSD) claims processing system and return a HIPAA compliant payment/remittance advice (835). Phase II development is anticipated to begin in December 2006 and implemented in July 2008.

- The Security rule was final in April 2003 with a compliance date of April 2005. DMH is continuing to remediate areas identified in the January 2004 gap analysis document.

- The National Provider Identifier (NPI) rule was final January 2004, with an effective date of May 23, 2005 and a compliance date of May 23, 2007. An assessment, gap analysis, and requirements plan was completed in May 2006. DMH began remediation efforts in June 2006 and is on schedule to meet the compliance date.

DMH'S APPLICATIONS DEVELOPMENT SECTION

DMH's Applications Development (AD) Section is divided into three units: Hospital Services, County Services and Headquarters Services. A brief description of the systems in each unit can be found under Criterion 2 for Adults and Older Adults.

INCIDENCE AND PREVALENCE OF SED

Definitions of serious emotional disturbance utilized in California are from the California Welfare and Institutions Code and the federal definition as established and disseminated pursuant to the Federal Public Health Services Act.

California Welfare and Institutions Code Definition

California's Welfare and Institutions Code, Section 5600.3 (a), defines children or adolescents with SED as follows:

> "For the purposes of this part, 'seriously emotionally disturbed children or adolescents' means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms.
>
> Members of this target population shall meet one or more of the following criteria:
>
> 1. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school, functioning, family relationships, or ability to function in the community; and either of the following occur:
>
>   a) The child is at risk of removal from home or has already been removed from the home.
>
>   b) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
>
> 2. The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.
>
> 3. The child meets special education eligibility requirements according to Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code."

Federal Definition of Target Population

The federal definition states that children with a serious emotional disturbance are persons:

A. From birth to age 18.

B. Who currently or at any time during the past year:

1. Have had a diagnosable mental, behavioral or emotional disorder of significant duration to meet the diagnostic criteria specified within DSM-III-R, that

2. Resulted in functional impairment that substantially interferes with or limits the child's role or functioning in the family, school or community activities.

PREVALENCE METHODOLOGY

A number of needs assessment methodologies have been used in the past by the DMH. In the late 1980s, the DMH contracted for a needs assessment study with Dr. Ken Meinhardt and his collaborators. They used rates from the Epidemiological Catchment Area (ECA) Study and applied them based on the demographics of California's counties. This resulted in a rate for major mental disorders of 6.15 percent for adults. In 1993, the DMH again contracted with Dr. Meinhardt for a prevalence study based on the criteria for the target population that were specified in law. They were very restrictive and defined the target population based on diagnosis, functioning level, duration of disorder, and likelihood of being eligible for public assistance. This resulted in a rate of 1.6 percent, which was used for several years. However, since then, the DMH and county mental health programs have taken on increased responsibility to serve populations beyond the target population. For example, with the consolidation of Medi-Cal mental health specialty services, clients who meet medical necessity must be served. Also, California's welfare reform program (CalWORKs) has provided funding for mental health services needed to assist in employment.

The Center for Mental Health Services contracted for a study of the prevalence of mental disorders among adults. The results of this study were published in the 1999 *Federal Register* and indicated prevalence rates of serious mental illness (SMI) of 5.4 percent and severe and persistent mental illness (SPMI) of 2.6 percent. Data reported below show both prevalence rates, although the 5.4 percent rate is more consistent with the broader population that county mental health programs serve.

STATE POPULATION TO BE SERVED

The State Department of Finance estimates that by 2008 the population of persons over 18 years of age in California will be 37,810,180. Based on the above rates from the *Federal Register* and this population data, it is estimated that there are 983,065 adults and older adults in the State with SPMI, and 2,041,750 adults and older adults with SMI. California, primarily through contracts with its 58 counties and two city mental health programs, expects to serve 420,000 adults and older adults in SFY 2007-08. The following table shows the total state population, number of clients, and prevalence by age group for SFY 2005-06 and estimated data for SFY 2007-08:

CALIFORNIA POPULATION ESTIMATES, CLIENTS SERVED AND ESTIMATED PREVALENCE OF PERSONS WITH SMI AND SED

	Total	0-8	9-17	18-64	65+
FISCAL YEAR 2005-06					
State Population	36,854,224	4,601,871	5,018,640	23,188,027	4,045,686
Clients Served	670,550	88,120	168,482	400,645	13,303
Estimated Population with SPMI/SED 7% SED and 2.6% SPMI	1,036,825	N/A	339,511	592,472	104,842
Estimated Population with SMI/SED 11% SED and 5.4% SMI	1,981,785	N/A	533,517	1,230,519	217,749
FISCAL YEAR 2007-08					
State Population	37,810,180	4,720,928	4,976,160	23,938,299	4,174,793
Estimated Clients to be Served	683,000	98,000	165,000	397,000	23,000
Estimated Population with SPMI/SED 7% SED and 2.6% SPMI	1,056,802	N/A	336,781	612,074	107,947
Estimated Population with SMI/SED 11% SED and 5.4% SMI	2,024,655	N/A	529,228	1,271,230	224,197

It is estimated that the number of persons to be served in SFY 2007-08 is expected to increase over the number of persons served in FY 2005-06. While California has experienced some budget deficits in past fiscal years, help has arrived in the form of the Mental Health Service Act (MHSA). Mental health service in California counties has been augmented with the passage of a statewide ballot proposition, which adds funds to the mental health system. The proposition established a 1% tax on personal incomes over a million dollars. These funds are being used to transform the California mental health system. The funds are to be used to deliver new and innovative services and in particular those that are evidence based. Overall it is expected that the MHSA will increase the mental health system statewide by about 15%.

While the MHSA funds are to be used for new services, the system to report these new services has not yet been developed. Due to the long running budget crisis, most counties have deferred procurement of new information systems. Changes required by the DMH due to the Data Infrastructure Grant (DIG) requirements and the MHSA have new pressure to county information systems to make changes. With the MHSA counties have the opportunity to apply to use funds earmarked for Information Technology to transform their reporting systems with a long term vision of developing an Electronic Health Record (EHR) for mental health. In addition, DMH is working with consultants to provide specifications that counties can use when changing their reporting systems that will more easily adapt to an EHR. This situation is complicated by California's 58 counties each of which will be or are in the procurement process for modification of exiting information systems or new systems and software. In many cases this is a long overdue purchase, but it adds uncertainty to the situation. As a result the number of clients served in SFY 2007-08 should increase based on additional service availability, but will depend on how soon counties are able to report. Much depends upon the final decisions county's make on fill their information system needs.

Data from the above table indicates that the rate of treated prevalence for persons with severe and persistent mental disorders was 65 percent, and the rate of treated prevalence for persons with serious mental illness was 34 percent.

There are a number of challenges that DMH faces in order to develop data on unmet mental health needs of the population by ethnicity. The first issue is the development of prevalence data in order to determine need. The Data Infrastructure Grant (DIG) is working on this at a national level. However, the rates that will be provided to states will address the total population. It is known that prevalence is slightly higher in poorer populations, which are the populations of concern to the state mental health program. And, although prevalence rates generally do not vary by race/ethnicity when controlling for socio-economic status, the Hispanic and African American populations tend to be over-represented in the lower socio-economic status. This would tend to increase the prevalence rates for these populations.

STATE-LEVEL REFINEMENTS OF PREVALENCE RATES AND SMI/SED DEFINITIONS

With the implementation of the MHSA there is increased pressure for California to refine the national prevalence rates. Counties have submitted a Community Service and Support (CSS) plan which must be data-driven. It is fortunate that over the last year workgroups of county, provider, and client and family stakeholders have been meeting around issues that have emerged as the result of the need to redesign DMH's data system to capture data elements to meet new federal requirements. The Data Infrastructure Grant (DIG) has served to promote the State's refinement of SMI/SED definitions and to develop State and county specific prevalence rates.

For several years, California has provided estimates of the SMI/SED population according to the method described above. While useful for the State as a whole, DMH was not able to respond to requests to provide prevalence rates of race/ethnicity by county. In 2003, DMH contracted with Charles Holzer, Ph.D., and an epidemiologist from the University of Texas Medical Board

(UTMB) to develop California specific prevalence rates. Dr. Holzer had done studies for several of the western States using a synthetic estimate model that applied prevalence rates developed from surveys conducted in the 1990's to the 2000 census data. Dr. Holzer used this same model for California and provided prevalence rates by county and selected demographic characteristics. DMH has maintained an ongoing relationship with Dr. Holzer and he is expected to provide California specific data when the new National Co-Morbidity Study-Revised (NCS-R) data is available in late 2006.

The following table shows the California SMI/SED population using the Holzer method and updated with more recent Census data:

COMPARISON OF STATE POPULATION, SMI/SED POPULATION, AND CLIENTS BASED ON HOLZER METHODOLOGY 2000 CENSUS WITH JULY 2004 UPDATE

	Total	Youth	Adult	18-64	65+
Census			**TOTAL POPULATION - 2000**		
Total Population	37,372,444	10,509,172	26,863,254	22,819,942	4,043,330
Household Population	36,524,190	10,455,031	26,863,223	22,218,503	3,879,156
Household Population Below 200% of Poverty	11,525,888	4,125,270	7,400,619	6,347,880	1,029,791
			SMI/SED POPULATION		
Total	2,466,518	788,188	1,665,522	1,483,296	202,165
Household Population	2,301,024	784,127	1,584,930	1,377,547	155,166
Household Population Below 200% of Poverty	1,017,054	367,496	649,558	587,843	61,715
			PERCENT SMI/SED POPULATION		
Total	6.6%	7.5%	6.2%	6.5%	5.0%
Household Population	6.3%	7.5%	5.9%	6.2%	4.0%
Household Population Below 200% of Poverty	8.8%	8.9%	8.8%	9.2%	6.0%
		CLIENTS	**SERVED FY**	**2002-03**	
Clients	659,704	203,499	456,205	435,609	20,593

SMI/SED is the estimated number of adults who have a serious mental illness or youth who have a serious emotional disturbance.

The above table shows the population and estimated prevalence for the total population, the household population, and the household population below 200 percent of the poverty level.

DMH's Statewide Quality Improvement Committee has adopted the policy to focus on the population below 200 percent of the poverty level to be used in determining penetration rates. However, there are some limitations in using that population because it includes persons in households only. Many of the persons served by county mental health programs reside in board and care facilities, or residential programs that are not included as households.

Another critical aspect of using the prevalence data to calculate penetration rate is the fact that the prevalence rates focus on the SMI/SED population. While the DMH uses diagnosis only to estimate the number of persons who are SMI/SED, it is not satisfied with using diagnosis as the single factor for determining SMI/SED. Both diagnosis and level of functioning are usually considered when determining if a person is SMI/SED. However, the reporting of functioning level has been incomplete. The DIG utilized workgroup process to address, among other things, the quality of reporting and the data elements it is using to estimate the SMI/SED client population. The DIG recommendations resulted in changes to the DMH's Client and Service Information (CSI) system which are being implemented beginning July 2006. DMH has changed to a DSM IV TR five axis diagnosis. Since this includes functioning level it is expected that this will give DMH a more accurate estimate of the number of clients who are SMI/SED.

The data provided by Dr. Holzer is based on the 2000 census, and the client population shown in the table above is for FY 2003-04. Updates have not been done for more current years because the household population below 200 percent of poverty is not a sub-group of the population that is updated annually. This is only collected on a sample basis at the time of the Census, which is every ten years. The population at lower income levels is growing at a higher rate than average, so the DMH is exploring alternative data sources or methodologies that could be used to update the prevalence data for persons below 200 percent of the poverty level annually.

The DMH believes that the estimates provided by Dr. Holzer showing prevalence rates by demographic characteristics and county are an improvement over using national rates. However, more work needs to be done to update the data, to include parts of the non-household population that would receive mental health services from county mental health, and to refine the data elements that are used to estimate the number of clients who are SMI/SED.

State-Level Performance Indicator Description

In May of 2004 prior to the passage of the Mental Health Service Act (MHSA), the Department presented county level prevalence data to all California counties. Since that time the data has been used extensively by counties as they develop their Service Plans for how they will use their MHSA funds.

In the Departments' continuing efforts to aid counties to refine estimates of their target service population DMH has contracted with the Department of Health Services and the University of California, Los Angeles to add additional questions to the California Health Information Survey (CHIS). This is an annual survey, which collects data on the health status of Californians. It was included the K-6 in the survey cycle for 2006. The K-6 is a set of questions developed and tested by Ron Kessler, Ph.D. designed to yield a mental health prevalence estimate. This will give us an alternative method to look at prevalence. The sample size is over 50,000, which will allow DMH to use it on a county level and help us to refine our previous prevalence estimates. While the survey is only for persons 18 years and older, we think that it will also allow DMH to have more detail on the ever-growing older adult population. To date DMH has received summarized data, but DMH will receive data sets which will be made available to counties for their on-going MHSA planning process.

In April of 2005 California Department of Mental Health received an administrative supplement from CMHS to analyze and coordinate the addition of the Psychological Health Questionnaire (PHQ-8) to the Centers for Disease Control's (CDC) 2006 Behavior Risk Factors Surveillance Survey (BRFSS) for California. Preliminary data has been made available and will give, when combined with other data, an interesting regional and national perspective. In addition, CMHS has announced that California will receive an additional administrative supplement to add the Kessler 6 (K-6) to the California BRFSS for 2007. This will provide more information for a national perspective on mental health prevalence when combined with the other data on health and health conditions available in the BRFSS data.

Criterion 2: Mental Health System Data Epidemiology

State Plan Performance Indicator Description

Goal:	At the county level, more accurately estimate the number of children who meet SED criteria.
Objective:	By June 30, 2007, obtain the incidence of children and youth, by ethnicity, being served by both the mental health system and the juvenile justice system in each county.
Population:	Children and youth ages 0-18 in the juvenile justice system with SED who are receiving mental health services
Criterion:	Mental Health System Data Epidemiology
Brief name:	Juvenile Justice Study
Indicator:	Report on the number and ethnicity of children and youth in the juvenile justice system receiving mental health services who meet the criteria for SED and an evaluation of the quality of this data as reported by counties.
Measure:	Report on the number of children and youth in the juvenile justice system receiving mental health services who meet the criteria for SED and an evaluation of the quality of data reporting, including any needed recommendation to improve reporting.
Source(s) of Information:	Client and Services Information (CSI) Data System. Children to be studied are those in the data element "Legal Class" designated as WIC Section 600.
Special Issues:	The legal status is a periodic data element that may not have consistent reporting by counties and this could impact data quality.
Significance:	This study is important because of the ethnic disparities of juvenile justice involvement, the reported high proportion of youth in the juvenile justice system with SED, and the high proportion of ethnic children and youth in California. In addition, EPSDT funds are not available to provide mental health services for incarcerated youth. It is necessary to understand the magnitude and scope of the problem in order to develop strategies to address it.

Fiscal Year: 2007

Population: **Children and Youth with SED**

Criterion: Mental Health System Data Epidemiology

(1) Performance Indicator:

1: Report on the number of children and youth in the juvenile justice system receiving mental health services

(2) FY 2006 Actual Not applicable

(3) FY 2007 Project Not applicable

(4) FY 2007 Objective By June 30, 2007, obtain the incidence of children and youth, by ethnicity, being served by both the mental health system and the juvenile justice system in each county.

(5) % Attain

Criterion 2: Mental Health System Data Epidemiology

Name of CMHS Core Performance Indicator: 1. Increased Access to Services

Population: Children with SED

California mental health system's goal is always to increase access to services; however, the funding sources for mental health services have not been stable in recent years. Funds for mental health services have not kept pace with population growth forcing counties to reduce services to all clients and focus on serving only the most seriously ill.

By imposing a 1% tax on taxpayer income in excess of $1 million, the Mental Health Services Act increases funds available for mental health care for new, innovative and transformational services and supports for the previously unserved or underserved persons with mental illness. The determination of how funds are used at the local county level is based on multi-stakeholder input and the individual needs of local communities; however, MHSA dollars typically cannot be used to supplant or replenish fund losses in existing programs. County community services and supports began in January 2006 and target unserved and underserved adults, older adults, children/youth and transition-age youth with SMI/SED.

DMH continues to estimate that there will be an increase of 10,000 to 15,000 in the number of unserved and underserved SED/SMI clients served over the first three years of MHSA implementation (an average of 4,166 or 0.79% per year). Based on an estimated increase of 0.8% for children and youth with SED served, we met our target for the current SFY. We expect a similar increase of 0.79% of children and youth with SED served for the upcoming SFY 2006-07.

Fiscal Year	2004-05 Estimated Actual*	2005-06 Estimated Actual*	2006-07 Target
Performance Indicator for children and youth with SMI/SED	159,585	160,862	162,133
Estimated Change		1,277	1,271

CRITERION 4. TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS

- **The plan provides for the establishment and implementation of outreach to, and services for, such individuals who are homeless.**

- **The plan describes the manner in which mental health services will be provided to individuals residing in rural areas.**

CHILDREN AND YOUTH WHO ARE HOMELESS AND HAVE BEEN DIAGNOSED WITH A MENTAL ILLNESS

Impacts to county level services and funding for foster youth exiting the system and youth served by the juvenile justice systems have created challenges for this population. With many county and state level initiatives facing severe budgetary crisis or termination, county program administrators and DMH continue to work on maintaining safety networks for homeless youth.

County programs, through the use of their interagency case management committees, maintain active supervision of youth known to the system, and in the process of exiting specific county services. To the extent that resources are available, and that the youth willing to participate, these case management teams make referrals to housing, employment and education institutions. There are many other youth in the larger counties that fall outside of the traditional case management committees' scope of work and oftentimes the interests of these youth are represented by the public health officers, law enforcement and local youth hotlines. DMH has been working with the Adolescent Health Work Group, a non-profit group operating out of the San Francisco Bay Area, to develop a list of shared concerns and strategies for outreach to these youth, and the referral to necessary mental health services.

DMH continues to work with existing state level efforts addressing the conditions of homeless youth including participation in the Foster Youth Initiative-Workforce Investment Act work group. Through the combined efforts of the State's employment and training agencies, social services, high schools and colleges, private foundations, and other human service departments several pilots have been initiated at the local level to promote improved coordination among the local agencies.

With the direct delivery of services coordinated at the county level in California, local communities are being stretched to maintain necessary services. The long standing practice of using mixed funding streams to maintain programs that address the needs of transitional youth is very essential this budget years as funding reductions in Medi-Cal, TANF, WIC, Food Stamps/GA, SSI, County Primary Care Health funds, Section 8 Housing, College financial aid and other county funds are expected.

While there is a current fiscal crisis facing California, the passage of the Mental Health Services Act will provide some opportunities to the counties to address the issues of homeless in children and youth. Homeless individuals needing mental health services are a primary group focused upon in the development of the MHSA. Many youth become homeless due to the lack of adequate transition systems as they approach young adulthood; Transition-Aged Youth (16 to 25) are one of the target groups be addressed in the county's MHSA plan for Community Services and Supports. Counties are currently in the process of developing their plans in this area. In the coming year, counties shall be

submitting these plans, and DMH staff will be working with the counties to implement new efforts to serve this population. DMH has provided additional resources to four consumer advocacy groups to augment current efforts to engage or do outreach to transition aged youth.

SUPPORTIVE HOUSING FOR TRANSITION-AGE YOUTH

Supportive Housing Initiative Act (SHIA)

As a part of a larger strategy to address issues of homelessness for individuals with mental illness, in SFY 1999-2000 the DMH funded two supportive housing demonstration projects for transition-age youth. These initial projects targeted young adults between the ages 18-25 who were homeless, or at risk of homelessness, and had a serious mental illness. Sacramento and Yolo Counties were awarded three-year grants to provide an urban and a rural demonstration of supportive housing for this special needs population. The two projects met their initial target goals for housing and services, and received two additional years of funding to support services through June 2004.

The Supportive Housing Initiative Act (SHIA), which is discussed under Criterion 1 for Adults, was passed into law in SFY 1998-99, and was subsequently allocated a total of $48.2 million in General Funds for the development of supportive housing projects for individuals with disabilities. Under the SHIA program, DMH sponsored the development for seven supportive housing projects that specifically focus on transition-age youth/young adults with disabilities.

These SHIA projects for transition age youth employ a range of models, from congregate living situations to young people having their own studio apartments. In spite of these differences, all of the projects offer permanent housing with a variety of supportive services on-site and in the community. Examples of two projects funded in San Francisco County are the Ellis Street Project and Gastinells's Supportive Housing. The Ellis Street Project, which is managed by Larkin Street Youth Services, houses formerly homeless young adults. Some of the tenants are run-aways and have lived on the streets, and others have exited the foster care system. This project also has six units of housing for individuals with HIV/AIDS. Gastinell's Supportive Housing targets young women with disabilities who have aged out of, or are emancipated from, foster care. This congregate living project is located in a large three-level home and each tenant has her own room. Clients may receive rental assistance and a range of supportive services, including strong linkages to culturally appropriate educational and health services in the community.

Transition-age youth are also part of the target population for AB 34/2034 programs that provide comprehensive, integrated services to persons with a mental illness who are homeless or at risk of homelessness (See Criterion 4 for Adults/Older Adults). These programs are responsible for providing services that include, but are not limited to, mental and medical health treatment, housing, employment, substance abuse, money management, and benefits assistance. Currently these programs provide services to approximately 500 youth between the ages of 18 and 24.

All of these projects have added much to our understanding of both the service and housing needs of young adults with SED/SMI.

Housing Challenges for Transition-Age Youth

Transition-age youth (TAY) moving into the world of independence has many challenges to endure, but none may be as great as securing adequate, affordable, stable and safe housing. The lack of

affordable housing, coupled with extreme poverty, is the underlying cause of homelessness in the United States. Consider the following facts gathered by the Child Welfare League of America.

Homeless youth become homeless for a variety of reasons, as do homeless adults and families. But some of the common avenues into homelessness for youth include:

- Separating from her or his already homeless family
- Leaving home to escape physical or sexual abuse
- Being thrown out of home by parents/guardians
- Emancipating from the foster care system
- Leaving an intolerable placement in an institution after having been placed there from her or his family
- Immigrating unaccompanied to the United States
- Unsuccessful experience in public school, which can lead to withdrawal from both home and academic life
- Difficulty coping with the symptoms of mental illness
- A TAY who has not developed sound financial skills, but lacks access to a payee, may be left homeless when impulsive decisions are made
- Often a combination of above factors may develop

The reason that youth do not emancipate fully until 28 is that youth are dependent on the relationships and support that families can provide. Youth need to know that they can leave home, but that the emotional and financial support is still available in times of need. If a TAY has been disappointed in relationships or if personal interruptions happen, and the TAY needs to forge ahead in life alone, the chances for becoming homeless dramatically increase. When a TAY is in a congregate living situation, negative events can happen when roommates transition too quickly, or when the TAY finds him or herself bouncing from residence to residence without consolidating gains. Adults who want to assist a TAY in securing a living situation may be wise to promote environments where youth can live together with a mature youth in a leadership role to provide oversight. In summary, the significant barriers to a TAY finding a successful rental situation include:

- There will be an economic barrier. The TAY will not have the work history or the income to qualify for fair rate market housing stock. They will not pass the credit check.
- They will not have the references from successful past rental experiences.
- The TAY will not have clear information about what “sheltered” or “subsidized” housing programs are available. Once they discover a resource, they will need assistance to comply with all requirements.
- Once they are successfully housed, they will need assistance and support to stay in the house.
- If the youth is accepted into a subsidized housing program, they will need intensive support so they do not become overly reliant on the resource and continue to work towards increasing independence.
- Individuals or agencies supporting youth don’t always have knowledge about each other’s programs. They do not always collaborate.
- The TAY with a disability of mental illness will have all the above stated challenges with the additional burden of dealing with the disability that may have contributed to the condition of homelessness in the first place.
- There are few Board and Care Facilities that accept youth, and often the facility will also accept older adults who may not be compatible with the TAY lifestyle and needs.

- On an emotional and financial level, if the TAY perceives that he or she has a severed relationship with the adults in his or her life; it will be far more difficult to feel secure in living in an independent setting.
- Congregate living situations, though the most desirable housing setting for the TAY, may not be available in the community where the TAY actually wants to live.
- Youth without financial or emotional support of family will find entering into the independent world far more difficult than youth who have this safety net to fall back on. Youth transitioning out of the foster care system are most vulnerable to setbacks in finding a successful place to live.

Recommendations For County Administrators Regarding TAY Housing Resources

TAY who are homeless or at risk of homelessness need special resources to assist them in overcoming the above barriers to finding adequate housing. The following are resource-building treatment strategies developed by the California Mental Health Directors Association, Children's System of Care/Adult System of Care, Transition Age Youth (TAY) Subcommittee, published April 29, 2005:

- TAY with mental illnesses needs intensive case management beyond high school graduation. Since this is 90% reimbursable under EPSDT Medi-Cal, providing case management is a good investment in the TAY will make a tremendous difference. The County Administrator must realize that even if the diagnosis is less serious than for other adults, as long as medical necessity exists for Medi-Cal, it is advantageous to both the youth and the department to provide specific mental health supports for this population. By giving the TAY population support in the early years of emancipation, the youth is more likely to be successful in his or her living situation.
- As county mental health departments identify housing resources for their clients, they must carve out stock that will be used for youth who will need subsidized assistance. Housing options must be thought of in the context of what is developmentally appropriate for this age. As discussed above, congregate supervised living arrangements that allow for sufficient privacy reflect most clearly the needs of the TAY population. The less a TAY congregate living situation looks like a residential treatment facility, the more likely the TAY will see it as a place they want to be.
- Every county should have a housing collaboration that meets regularly to review the resources and attend to the needs of homeless youth, those aging out of foster care, and TAY with mental illness for referral into the "sheltered" or "subsidized" housing stock.
- TAY should not be placed in board and care facilities with older adults. TAY needs to have an environment of hope and recovery and a home environment that is developmentally and culturally appropriate. If the home is licensed as a Board and Care, there should be a transitional theme that encourages youth to expand boundaries in a safe context.
- In supported housing programs, the ideal TAY climate can be fostered. There should be social support from peers and the service coordination necessary to assist with life's important decisions. The youth needs to be simultaneously involved in an educational or vocational program that will promote further independence. In such a setting, the symptoms of mental illness can be stabilized and TAY have the opportunity to self-monitor symptoms and balance activities in the outer world using the valuable experience of learning to live with a disability successfully.
- When TAY are still in a CSOC Program, it will take intensive collaboration with agencies involved as well as interested family members to create a service plan that will address the many needs that will develop after the "Freedom Birthday" of age 18. Only after a strengths-based assessment is completed, will the client and a clinician have established a trusting relationship in order to actually generate a client-driven culturally competent service plan.

- County Administrators need to be aware of family systems theory so that in the development and organization of programs, there is sensitivity to family members. Youth do not emotionally grow and thrive outside the context of the family system. The natural resources that the family and community can provide cannot be duplicated by an agency.

Housing Services Under the Mental Health Services Act

The Mental Health Services Act (MHSA) provides funding for services and supports that promote wellness, recovery and resiliency for adults and older adults with severe mental illness and for children and youth with serious emotional disorders and their family members. In order to receive MHSA Community Services and Supports funding, each county must develop a three-year program and expenditure plan. A portion of the MHSA funds can also be used for capital facilities and technological needs to support community-based integrated service experiences for clients and their family members, consistent with the county's Community Services and Supports Program and Expenditure Plan. Capital facilities can include housing and other buildings that enable mental health clients and their family members to live in the most independent, least restrictive housing possible in their local community and to receive services in community-based settings that support wellness, recovery and resiliency. Decisions about how to use the MHSA funds available for capital expenditures must be guided by the overarching transformation goal. The Department is fully vetted and actively involved in a public stakeholders process to solicit input on ideas for effective use of MHSA Capital Facilities funds. No decisions regarding implementation of plans for Capital Facilities funding will be made until all stakeholder input is considered.

SERVICES IN RURAL COUNTIES

Definition

The California Rural Health Policy Council defines rural areas as follows: "Rural areas are Medical Service Study Areas as defined by the Office of Statewide Health Planning and Development that have a population density of less than 250 persons per square mile and have no incorporated community with a population greater than 50,000 people." An additional criterion for the Rural Health Policy Council Rural Health Grants Program is that any area is rural if deemed so by the California Health Manpower policy Commission.

Provision of Services

All 58 counties in the State of California provide mental health services. To the extent that resources are available, they provide at least the minimum array of services for children and youth meeting the target population criteria. The following are modes of service provided:

- Pre-crisis and crisis services;
- Assessment;
- Medication education and management;
- Service coordination;

- 24-hour treatment services; and

- Rehabilitation and support services.

The DMH, in conjunction with CMHDA and CIMH, will work with small counties to implement fiscal and programmatic strategies consistent with these difficult fiscal times. As resources will allow, CIMH plans to continue with regional trainings in the areas of 1) evidence-based mental health treatment in the juvenile justice system; 2) multidimensional treatment foster care; and 3) evidence-based approaches to family therapy. Changing the practice models within counties will help to assure quality services and cost effective approaches.

State-Level Performance Indicator Description

Goal:	Expand services to children and youth with SED in rural counties.
Objective:	By June 30, 2007, update data on community-based outpatient services to children and youth with SED in rural counties and include race/ethnicity in the analysis.
Population:	Children and youth with SED who are homeless and/or who live in rural counties.
Criterion:	Targeted Services to Rural and Homeless Populations
Brief name:	Rural Services
Indicator:	Number of children and youth with SED receiving outpatient services and units of outpatient service provided to that population by race/ethnicity.
Measure:	Number of children and youth with SED receiving outpatient services and units of outpatient service provided to that population by race/ethnicity.
Source(s) of Information:	Client and Service Information (CSI) Data System
Special Issues:	
Significance:	

Fiscal Year: _____

Population: **Children with SED**

Criterion: **Targeted Services to Rural and Homeless Populations**

(1) Performance Indicator:

1: Rural Services

(2) FY 2005
Actual **Not applicable**

(3) FY 2006
Project **Not applicable**

(4) FY 2007
Objective By June 30, 2007, update data on community-based outpatient services to children and youth with SED in rural counties and include race/ethnicity in the analysis.

(5) % Attain

CRITERION 5. MANAGEMENT SYSTEMS

- **The plan describes the financial resources and staffing necessary to implement the requirements of such plan, including programs to train individuals as providers of mental health services, and the plan emphasizes training of providers of emergency health services regarding mental health.**

- **The plan contains a description of the manner in which the State intends to expend the grant for Fiscal Year 2007 to carry out the provisions of the plan.**

COMMUNITY RESOURCES FOR
CHILDREN'S PROGRAMS
FISCAL YEAR 2006-2007

DMH – State Hospitals	$ 3,400,000
DMH – Local Assistance	1,200,000
DMH – Managed Care	57,744,000
DMH – CMHS Block Grant	14,596,000
DMH – EMHI (AB 1650)	10,000,000
DMH – Healthy Families	17,850,000
DMH – EPSDT/TBS	701,528,000[1]
DMH – Short-Doyle/Medi-Cal Match	168,170,000[1]
Total DMH	**$974,488,000**
Realignment Funds Base	211,337,000
Total Community Programs	**$1,185,825,000**

[1]Reflects cash disbursements for Fiscal Year 2006-07.
Note: The information included for Short-Doyle/Medi-Cal Match does not reflect the Federal Financial Participation (FFP) for Managed Care Inpatient Services.

HUMAN RESOURCES DEVELOPMENT

There is a current crisis in the number of mental health professionals trained and able to provide appropriate services to the most severely disabled public mental health clients, with projections for significant increased needs as we move into the 21st century. These acute shortages include staff serving clients who are bilingual/bicultural and those who live in both inner cities and in rural areas. There are also critical shortages of child psychiatrists as well as professionals trained to serve the elderly and other special populations. In addition, California's state hospitals are experiencing acute shortages of psychiatric technicians, nurses, and other clinical staff.

The DMH, in collaboration with the Administration, CMHDA, CMHPC, and other concerned stakeholders, will be addressing the current and future staffing needs in the coming fiscal year. The CMHPC has identified the shortage of human resources at all levels as one of the most urgent issues facing the mental health system. In an effort to address the crisis facing the mental health system, the CMHPC convened the Human Resources Summit 2000. Through a collaborative process, key decision-makers determined nine major aspects of the staffing shortage including: expanding the capacity of postsecondary education; work readiness in the classroom; multi-lingual and multicultural pipeline strategies; school-to-career strategies; job retraining for mental health occupations in the public sector; direct consumer and family member employment; licensing boards and professional recruitment; rural strategies; and community redefinition, corporate partnerships, and collaboration.

The Human Resource Project was developed to implement the action plan resulting from the March 2000 summit. The overall mission of the Human Resource Project is to increase the mental health workforce and to increase its cultural competence and diversity. Diversity is defined very broadly to include ethnicity, language, gender, age, and clients and family members. As of June 30, 2006, the Human Resource Project has accomplished the following:

- Conducted a professional symposium with secondary education partners, and other stakeholders to develop strategies to increase mental health career opportunities in secondary educational programs.

- Convened a series of informational meetings and roundtable discussions with consumer and family member employment training programs to document strategies to engage and include consumers and family members from diverse ethnic communities in training programs.

- Produced a Developing a Curriculum (DACUM) for marriage and family therapists working with California's public mental health system. A DACUM is a nationally recognized, standardized approach to job analysis that produces a complete job profile including prioritized tasks. The DACUM has established a foundation for developing or enhancing current curricula offered in marriage and family therapy education programs that is relevant to practice in California's public mental health system.

- Developed a DACUM project for psychiatric technicians. The DACUM project will compare the results of the community-based agency DACUM with those from a DACUM conducted with psychiatric technicians from state hospitals. The goal is to determine if current certificated programs in the State are providing the depth and breadth necessary for the current level of practice required in California's public mental health system.

- Developed an Integrated Dual Diagnosis DACUM (IDD-DACUM). A significant proportion of clients in the public mental health system have co-occurring, mental health and substance abuse issues. However, there is a dramatic shortage of mental health workers qualified to provide integrated mental health services. The developed DACUM produced the information necessary to begin the process of producing a curriculum for training staff to address this shortage.

- Published a Psychiatric/Mental Health Nurse Practitioner brochure targeted to various levels of the career ladder. The brochure will assist in an effort to recruit individuals into the profession and promote the increased utilization of psychiatric mental health nurses in California's public mental health system.

- Published a guide entitled "A Guide for Developing Mental Health Components in High School Academies." This guide encourages the development of local partnerships among local mental health employers and education programs that will result in the establishment of mental health components in high school health academies and other education programs. This partnership should stimulate a workforce pipeline that attracts youth, especially from ethnically diverse backgrounds, into pursuing mental health careers.

- Produced a report entitled, "Consumer and Family Member Employment in the Public Mental Health System." The Human Resources Project Consumer and Family Member Task Force developed the report to promote the employment of consumers and family members in the mental health system. The study determined that approximately 1,600 consumers and family members were employed in 36 counties in both full- and part-time positions. It identified both successful model programs for replication and barriers that need to be overcome to increase employment opportunities.

- Collaborated with Assembly Member Leland Yee's Office to develop Assembly Concurrent Resolution 54, a measure that proclaims the 3rd week of May of every year as Mental Health Occupations Week. The resolution encourages mental health professionals, persons with mental illness, family members, schools, academic institutions, and policymakers to work together to promote mental health occupations.

- Completed the initial phase of a retired persons project that placed retirees in job/career roles in the California public mental health system.

- Collaborated with Assembly Member Leland Yee's Office to develop AB 938, a bill that extends a loan repayment program administered by the Office of Statewide Health Planning and Development to mental health professionals. This bill will assist students in managing the expenses of going to school in exchange for the commitment that, upon graduation, individuals will serve in eligible county facilities or health manpower shortage areas that are culturally and linguistically diverse.

- Convened a series of focus groups with multicultural social workers from various agencies, including mental health, social services, and alcohol and drug, to determine how to make mental health occupations and academic programs more attractive to bilingual and bicultural students, and produced a summary report of recommendations for schools of social work and the mental health system.

- Advocated for federal legislative staff to support current federal funding efforts to assist individuals who choose mental health occupational and educational pathways.

- Collected data on vacancy rates among 22 occupations working within the public mental health system.

- Researched the capacity of the educational system to train professionals and paraprofessionals for work within the public mental health system.

- On behalf of the DMH, staffed the SB 1748 Task Force and prepared a report to the State Legislature.

- Convened a workgroup to address the shortage of nursing professionals and expand the utilization of psychiatric nurse practitioners in California. As an outcome of this workgroup, the CMHPC published a manual entitled "Expanding the Use of Psychiatric Nurse Practitioners in Behavioral Health Settings: Resource Materials."

The Human Resource Project intends to produce at least the following products and advance the following activities in the coming fiscal year:

- Convene a consumer and family member workgroup to make recommendations to the CMHPC and the DMH on consumer and family member employment programs and opportunities that are consistent with the recommended activities of the Mental Health Services Act Education and Training Program components.
- Provide technical assistance to local mental health departments on how to engage secondary educational programs as part of a long-term workforce development strategy.
- Establish a postsecondary educational workgroup to provide the CMHPC and DMH with information on how to develop a "core-curriculum" that can be used in postsecondary educational programs to assure the production of a cultural proficient "work-ready" workforce from educational programs. In addition, the group will advise the DMH on how to develop requirements related to the provision of loan repayment programs that will hold educational programs accountable for increasing student diversity and cultural competency.
- Facilitate the development of a DACUM for Transition Age Youth. The MHSA provides a unique opportunity to expand services to youth who are connected to a variety of service systems throughout California's Social Welfare system. The goal of this DACUM is to utilize an expert pool of youth to oversee a job development analysis of professionals they have identified. The DACUM will communicate to professionals and organization the skills and abilities that are necessary for individuals who are providing services to youth.
- Develop A DACUM for Child and Adolescent Psychiatry. The DACUM will establish a foundation from which to enhance the focus of residency programs by determining the current job environment, skills, and functions that child and adolescent psychiatrists are providing in the public mental health system. The DACUM will facilitate the implementation of clear educational pipeline strategies to attract individuals into the field, as well as, enhancing curricula.
- Develop a DACUM for Telemedicine. This DACUM will set a foundation for understanding and advancing the skills and abilities of those practicing telepsychiatry and set a foundation for

additional work in developing a core curricula to be utilized by individuals who are mental health professionals to provide culturally competent services via technology.

- Develop a DACUM for Peer Support Specialists. The DACUM will allow for a standardized review of what current peer support professionals are doing in the public mental health system. In addition, the DACUM will enable employers to determine the training that will best enhance the work of peer support, allowing organizations to develop career ladders that link to other professions for consumers who work in these positions.

- Facilitate a time-limited Recovery Standards Task Force. The charge of the taskforce will be to develop standards and core-competencies that can be utilized by providers and community-trainers to create a consistent understanding of wellness, recovery, and resiliency. In addition, those evaluating Community Services and Supports plans and education and training proposals required by the Mental Health Services Act will have a standard operationalized set of components to document.

- Establish a time-limited workgroup to focus on the unique needs of older adults within the public mental health system. The goal of the workgroup will be to assist in the design of a statewide Summit, highlighting the current understanding of service needs for individuals age 55 to 59, and those older adults who are 60 years and older. The Summit will have an emphasis on the occupational needs that will be required to meet the needs of this special population and will serve as a first-step by the CMHPC in exploring both the service and occupational needs of special populations in the public mental health system.

- Continue to promote the recruitment of retirees in California's public mental health system. Developing strategies to recruit retirees will assist county mental health departments and community-based agencies in being able to have an adequate workforce to provide services.

- Expand post-secondary educational opportunities for mental health occupations through encouraging distance education career ladder programs and promoting secondary and post-secondary educational programmatic coordination.

- Provide technical assistance to regional and statewide organizations that are currently developing workforce and educational recruitment and retention plans.

In addition, under the Mental Health Services Act (MHSA), the DMH must collect county data, complete a statewide occupational needs assessment, and develop a five-year plan addressing a statewide mental health education and training program. In meeting this legal obligation, DMH is committed to increasing the quantity and quality of trained persons available for employment in the mental health system while increasing family and consumer involvement in service delivery and encouraging development of a diverse workforce. The MHSA envisions a system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children and youth with serious emotional disorders and their families. In addition, mental health services should be effective in helping adults, children and families reach their goals through the development of individualized service plans and delivery of evidence-based practices. The MHSA education and training component offers an opportunity to transform the system to reflect these values. Accordingly, DMH decision-making will include principles that promote and support education and training efforts that reflect client recovery/wellness and resiliency. The Department is fully vetted and actively involved in a public stakeholders process to solicit input on ideas for effective use of MHSA

Education and Training funds. No decisions regarding implementation of plans for Education and Training funding will be made until all stakeholder input is considered.

DEPARTMENT OF MENTAL HEALTH TRAINING

The DMH State Hospitals' Training Officers provide a wide range of training opportunities for State Hospital employees. The Headquarters Training Officer reviews, approves and tracks headquarters employee training requests. The Headquarters Training Office also acts as liaison with State Hospital Training Officers regarding issues that impact all DMH employees.

Current staff development efforts are focused on:

- The State Hospitals conducting annual training needs assessments;
- The State Hospitals implementing an annual training plan; and
- The State Hospitals evaluating the success of the plan at the conclusion of the fiscal year.

Training currently offered by the DMH State Hospitals and the Headquarters Training Office includes, but is not limited to, the following:

- Training required by the Government Code, Department of Personnel Administration policy, DMH policy, agreements between the State of California and employee union organizations, and, at the State Hospitals, the Joint Commission on Accreditation of Healthcare Organizations.
- Training using the DMH computer network, which links DMH headquarters, the State Hospitals, and field offices.
- PsychLINK professional clinical training sessions presented via DMH satellite. Continuing Education Credits are offered and other departments are invited to attend. The Hospital Training Offices are responsible for registering, grading and faxing test results for staff to receive continuing education credits to maintain their licensure. Topics include "Compliance with Antidepressant Therapy" and "Beyond Efficacy: Obesity and the Psychotic Patient." These sessions are also videotaped and can be viewed at later dates.
- State Hospitals presenting training programs with DMH staff and participants from county mental health programs on such topics as dual diagnosis, biopsychosocial treatment planning, and vocational rehabilitation programming.

The DMH Information Technology unit coordinates with the data center, outside vendors, and headquarters based computer training for DMH employees. Computer training provided by outside vendors includes Microsoft Windows 2000, Word, Excel, PowerPoint, Visio, and other appropriate courses. The Health and Human Services Data Center (HHSDC) offers one-to-three day courses in standard PC applications as well as longer and more specialized subjects. The Information Technology unit also provides consultation to DMH staff in selecting the most appropriate computer training classes.

The CMHPC, in partnership with CMHDA, CIMH and the California Association of Local Mental Health Boards, is continuing development of a statewide training plan for mental health

professionals, direct consumers and families to communicate the emphasis on client-directed services.

The DMH has contracted in the past, and will continue to contract with external providers and State organizations such as the CPS Human Resource Services, Health and Human Services Data Center, universities and community colleges for training. The scope of training topics includes managed care, dual diagnosis, children's SOC, performance outcomes, and independent living with a focus on employment.

The DMH has developed the capability for interactive videoconferences that links headquarters and all State Hospitals. In addition, some counties, other government agencies, and State universities have the same capability so the system can be used with local mental health programs as well. Teleconferences are presented to promote more efficient communication while saving travel costs and time. The videoconference unit also has a document camera and videocassette recorder so documents can be read simultaneously in several locations and conferences can be recorded. For the same cost savings reasons, DMH has installed a satellite dish at headquarters that allows the onsite down linking of important professional development programming from throughout the United States.

The DMH, the CMHDA, the CMHPC, and the California Association of Local Mental Health Boards want to stress the need for continued and expanded federal funding of Human Resources Development programs. These funds are essential to State and local efforts to train the State's mental health work force, especially in light of the unique multicultural and linguistic needs of California.

COMMUNITY AND EMERGENCY HEALTH SERVICES PROVIDER EDUCATION

DMH community and emergency health services provider education efforts include distribution of educational materials produced by NAMI California through a contract with DMH. In addition to a broad array of educational materials in print and electronic-media format on a wide range of mental health subjects, NAMI California has produced a number of videotapes designed to educate the public, particularly law enforcement and emergency health services providers, on the nature of mental illness and dealing with individuals in crisis. Additionally, NAMI California has developed a series of booklets that have been most helpful to families of newly diagnosed persons.

In SFY 2001-02, NAMI California designed and implemented a website that provides education and support to family members and consumers. The website provides family members and consumers with current information on serious mental illness 24 hours a day, 7 days a week. The website address is www.namicalifornia.org. In SFY 2004-05, NAMI California improved functionality of the site and expanded the number of languages supported by adding translations for Korean and Tagalog to Spanish and Chinese translations. NAMI California continues to update and maintain the website on a daily basis including contacting, verifying and updating over 3500current and new service providers that treat serious mental illness; maintaining and updating listings of local affiliates and organizations that assist families and consumers; maintaining, updating and facilitating Family-to-Family class schedules and registrations, researching, selecting, preparing and posting news stories relating to mental illness and mental health, including stories regarding government polices and programs, advances in treatment and pharmaceutical company announcements regarding new drugs, side effects and research. It is anticipated that DMH will continue to fund this effort in SFY 2005-06.

DMH supported the efforts of the Mental Health Association in California to update and print in both English and Spanish more copies of its brochure "*Reaching for the Light*," a resource guide for coping with mental health problems. The guide, designed to give information to mental health and emergency health services providers and the general public, provides information on all aspects of mental health and mental illness, including such topics as finding help for yourself, children, adolescents, adults and older adults; how therapy works; paying for mental health care; mental disorders; and choosing a mental health professional. DMH makes this guide available to providers and the general public upon request.

DMH Disaster Assistance Coordinator (DAC) maintains a liaison role with the California Department of Health Services and Emergency Medical Services Authority for emergency planning and assistance. As part of an inter-disciplinary training team, the DAC participates in an annual training course entitled "Disaster Bootcamp," which is offered to emergency medical and health services personnel. This presentation includes an overview of the mental health issues relevant to natural disasters and terrorist events and responder coping and stress management. The DAC is a licensed mental health clinician qualified to teach courses on mental health issues that emergency health services providers may experience in the course of their work.

EXPENDITURE PLAN FOR FISCAL YEAR 2007

The DMH will allocate the FY 2007 Community Mental Health Services Block Grant to local county mental health departments in State Fiscal Year (SFY) 2007-08. These funds will be used to promote the implementation of integrated systems of care and to fulfill the mission of the California mental health system. In addition, the DMH will allocate a portion of the block grant to support the CMHPC.

The DMH, as the State's designated recipient of the Block Grant, allocates the funds to counties either based on a legislated formula or on a competitive basis. The base allocation provides a stable, flexible and non-categorical funding base, which the counties can use to develop innovative programs or augment existing programs within their systems of care for adults with SMI or children with SED. In order to receive the base allocation, each county is required to submit an annual application or expenditure plan that includes a narrative detailing its intended use of the funds.

Block grant funding may also be awarded through a competitive process. The process is structured to encourage counties to adopt proven practices and to promote innovation and risk-taking by encouraging counties to explore new approaches.

The plan for expenditure of FY 2007 Block Grant funds includes:

- $44,679,426 in base allocation monies to 58 counties. This base includes an $8,059,000 set-aside to support existing efforts to provide integrated treatment services for individuals with a dual diagnosis of SMI and a substance abuse disorder;

- $3,987,515 to provide ongoing funding to support seven competitively awarded Children's System of Care programs (see the description of the Children's System of Care programs within this application's narrative);

- $2,000,000 to support two Integrated Services Agencies (ISA's);

- $200,000 to support Human Resource Development (HRD);
- 20,000 to support the efforts of the COJAC
- $3,279,000 for DMH Administrative and Support costs (includes funding for CMHPC).

The plan for expenditure also includes $534,361 to be allocated to counties to fund additional programs within their Adult and/or Children's System of Care.

The following chart summarizes the Department's proposed total SAMHSA Block Grant funds to be allocated for adult and children's mental health services for SFY 2007-08.

SAMHSA/CMHS BLOCK GRANT SFY 2007/08 PROPOSED EXPENDITURES

COUNTY	BASE ALLOC	DDX SET-ASIDE	HRD PROJ.	CHILDREN SOC	ISA FUNDING	CO-OCCURING DISORDERS	EXPENDITURE TOTAL
ALAMEDA	$ 539,193	$ 152,415					$691,608
ALPINE	$ 10,008	$ -					$10,008
AMADOR	$ 31,514	$ 8,477					$39,991
BUTTE	$ 241,046	$ 94,983					$336,029
CALAVERAS	$ 107,770	$ 11,903					$119,673
COLUSA	$ 51,745	$ 1,535					$53,280
CONTRA COSTA	$ 1,502,286	$ 76,984					$1,579,270
DEL NORTE	$ 110,117	$ 13,127					$123,244
EL DORADO	$ 96,628	$ 38,077					$134,705
FRESNO	$ 1,063,068	$ 418,899					$1,481,967
GLENN	$ 107,391	$ 8,700					$116,091
HUMBOLDT	$ 259,412	$ 45,532		$ 183,692			$488,636
IMPERIAL	$ 290,750	$ 64,292					$355,042
INYO	$ 159,328	$ 985					$160,313
KERN	$ 874,497	$ 231,820					$1,106,317
KINGS	$ 121,506	$ 47,879					$169,385
LAKE	$ 166,133	$ 28,454					$194,587
LASSEN	$ 85,725	$ 13,429					$99,154
LOS ANGELES	$ 11,557,984	$ 1,162,873		$ 1,012,034	$ 1,000,000	$ 20,000	$14,752,891
MADERA	$ 162,311	$ 45,596					$207,907
MARIN	$ 250,176	$ 98,581	$ 200,000				$548,757
MARIPOSA	$ 90,603	$ 2,534					$93,137
MENDOCINO	$ 31,462	$ 12,398					$43,860
MERCED	$ 395,715	$ 114,295		$ 351,535			$861,545
MODOC	$ 10,113	$ -					$10,113
MONO	$ 10,016	$ -					$10,016
MONTEREY	$ 402,330	$ 93,279		$ 740,475			$1,236,084
NAPA	$ 175,331	$ 69,089					$244,420
NEVADA	$ 58,112	$ 22,899					$81,011
ORANGE	$ 1,633,979	$ 559,023					$2,193,002
PLACER	$ 195,064	$ 46,365		$ 444,188			$685,617
PLUMAS	$ 209,881	$ 8,136					$218,017
RIVERSIDE	$ 2,072,058	$ 360,159					$2,432,217
SACRAMENTO	$ 1,441,610	$ 498,582					$1,940,192
SAN BENITO	$ 31,085	$ 12,250					$43,335
SAN BERNARDINO	$ 2,495,242	$ 610,357					$3,105,599
SAN DIEGO	$ 2,334,874	$ 878,852					$3,213,726
SAN FRANCISO	$ 1,991,209	$ 685,821					$2,677,030
SAN JOAQUIN	$ 828,294	$ 282,744					$1,111,038
SAN LUIS OBISPO	$ 123,444	$ 57,159		$ 254,061			$434,664
SAN MATEO	$ 681,091	$ 164,338					$845,429
SANTA BARBARA	$ 165,592	$ 33,828					$199,420
SANTA CLARA	$ 532,675	$ 172,184					$704,859
SANTA CRUZ	$ 94,886	$ 22,376					$117,262
SHASTA	$ 190,913	$ 75,228					$266,141
SIERRA	$ 48,653	$ 317					$48,970
SISKIYOU	$ 96,061	$ 22,840					$118,901
SOLANO	$ 117,288	$ 46,217					$163,505
SONOMA	$ 202,545	$ 42,804					$245,349
STANISLAUS	$ 530,536	$ 185,018		$ 1,001,530	$ 1,000,000		$2,717,084
SUTTER/YUBA	$ 265,571	$ 69,385					$334,956
TEHAMA	$ 169,739	$ 21,397					$191,136
TRINITY	$ 84,040	$ 2,042					$86,082
TULARE	$ 654,882	$ 201,143					$856,025
TUOLUMNE	$ 52,167	$ 16,616					$68,783
VENTURA	$ 219,205	$ 86,376					$305,581
YOLO	$ 195,572	$ 18,408					$213,980
COUNTY TOTAL	$ 36,620,426	$ 8,059,000	$ 200,000	$ 3,987,515	$ 2,000,000	$ 20,000	$50,886,941
DMH ADMIN/SUPPORT	**$ 3,279,000**						**$3,279,000**
							$0
GRAND TOTAL							**$54,165,941**

Criterion 5: Management Systems

State-Level Performance Indicator Description

Goal:	Support activities of the California Mental Health Planning Council (CMHPC) to serve as a statewide catalyst to address the shortage of mental health staff.
Objective:	By June 30, 2007, conduct a Peer Support Specialist DACUM (Developing a Curriculum)
Population:	Children diagnosed with SED
Criterion:	Management Systems
Brief name:	DACUM
Indicator:	A completed DACUM submitted to the Department of Mental Health
Measure:	A completed DACUM submitted to the Department of Mental Health
Source(s) of Information:	Work group convened to perform the DACUM process
Special Issues:	
Significance:	The employment of consumers is vital to the transformation of the public mental health system. In order to increase the level of consumer employment in the public mental health system, county mental health departments have developed the peer support specialist position. Understanding this occupational niche is critical to developing additional training programs and being able to expand career mobility opportunities for individuals who are working within the position. A peer support DACUM will allow for a more standardized review of what current peer support professionals are doing in the public mental health system. In addition, a DACUM will enable employers to determine the training that will best enhance the work of peer support, allowing organizations to develop career ladders that link to other professions for consumers who work in these positions.

Fiscal Year: 2007

Population: Children with SED

Criterion: Management Systems

(1) Performance Indicator:

1. Develop of Peer Support Curriculum

(2) FY 2005 Actual

(3) FY 2006 Project

(4) FY 2007 Objective: By June 30, 2007, conduct a Peer Support Specialist DACUM

(5) % Attain